



EACS
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GUIDELINES

Version 9.1
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English

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Introduction to the EACS Guidelines 2018

Welcome to the EACS Guidelines!

These Guidelines were developed by the European AIDS Clinical Society (EACS), a not-for-profit organisation, whose mission is to promote excellence in standards of care, research and education in HIV infection and related co-infections, and to actively engage in the formulation of public health policy, with the aim of reducing HIV disease burden across Europe.

The EACS Guidelines were first published in 2005, and are currently available in print, online, and as a free App for both iOS and Android devices. The Guidelines are translated to several different languages, and are formally revised at least annually for the electronic version and biennially for the printed version. The electronic version can, however, be updated at any given moment if the panels consider it necessary.

The aim of the EACS Guidelines is to provide easily accessible and comprehensive recommendations to clinicians centrally involved in the care of HIV-positive persons.

The EACS Guidelines are covering a relatively large and diverse area geographically, with different national levels of access to care. As a natural consequence, the Guidelines aim to cover a relatively wide range of recommendations as opposed to the often more uniform national guidelines.

The Guidelines consist of five main sections, including a general overview table of all major issues in HIV infection, as well as detailed recommendations on antiretroviral treatment, diagnosis, monitoring and treatment of co-morbidities, co-infections and opportunistic diseases.

Each respective section of the Guidelines is managed by a panel of experienced European HIV experts, and additional experts, where needed. All recommendations are evidence-based whenever possible, and based on expert opinions in the rare instances where adequate evidence is unavailable. It was decided not to provide formal grades of evidence in the Guidelines. The panels make decisions by consensus or by vote when necessary. Yet, it was decided not to publish results of the votes or discrepancies if any.

A list of the main references used to produce the Guidelines is provided as a separate section. Please reference the EACS Guidelines as follows: EACS Guidelines version 9.1, October 2018. Video links to the EACS online course on Clinical Management of HIV are provided throughout the Guidelines, see [Video links](#).

The diagnosis and management of HIV infection and related co-infections, opportunistic diseases and co-morbidities continue to require a multidisciplinary effort for which we hope the 2018 version of the EACS Guidelines will provide you with an easily accessible and updated overview.

All comments to the Guidelines are welcome and can be directed to guidelines@eacsociety.org

We wish to warmly thank all panellists, external experts, linguists, translators, the EACS Secretariat, the Sanford team and everyone else who helped to build up and to publish the EACS Guidelines for their dedicated work.

Enjoy!

Manuel Battegay and Lene Ryom

October 2018

Summary of Changes from v9.0 to v9.1

ART section

What to start with:

- New recommendation to use an INSTI as preferred third agent in treatment-naïve persons commencing ART, page 12
- TAF/FTC/BIC, TAF/FTC/DRV/c and the new formulation of RAL 1200 mg qd added to the recommended regimens, page 12
- Additional footnote on use of TDF and TAF and use of generics, page 13
- TAF/FTC/EVG/c has been downgraded to alternative regimen, page 13
- Dual regimen with DTG+3TC added to alternative regimens, page 13

Switch strategies:

- Added recommendation to review drug-drug interactions with ARVs and concomitant medication in case of switch, page 15

Virological failure:

- Changed recommendation to include DTG based regimens, page 16

Treatment of HIV-positive pregnant women:

- New recommendations against use of DTG, RAL 1200 mg qd, BIC, and DRV/c during pregnancy, page 17

Co-morbidities and related sections

- All DDI tables have been updated and revised with data on BIC, pages 23-33 and 86
- To make room for BIC, data on the older and less used ZDV has been moved to the DDI tables footnotes, pages 23-33 and 86
- It was agreed to await additional studies of BIC before adding data on BIC to the adverse drug effect and other tables
- Screening recommendations for HCC have been revised in collaboration with the co-infection panel, pages 8, 40, 58, 81
- Data on the fixed dose combination TAF/FTC/DRV/c has been added to the tables of swallowing difficulties and dose adjustment for renal and hepatic insufficiency, pages 36, 35 and 34
- Practical points on diagnosing hepatic fibrosis have been added in collaboration with the co-infection panel, pages 8, 58 and 83
- Minor changes have been added to antihypertensive management and treatment section to underline lifestyle changes and use of combination drugs, pages 43 and 44
- In the SOT section, it has been specified that HIV-positive persons can receive organs from living (renal) and deceased (all types of SOT) HIV-negative donors, and the use of HIV-positive donor organs for HIV-positive recipients is under evaluation, page 79

Co-infections section

- HCC screening recommendations have been updated. This also includes changes in the cancer and liver sub-sections of the co-morbidity section, pages 8, 40, 58 and 81
- Practical points on diagnosing hepatic fibrosis have been added. This also includes changes in the liver sub-section of the co-morbidity section, pages 40, 58 and 81
- Wording regarding prevention of HCV MTCT has been added, page 81
- Section on HEV has been added, pages 6 and 81
- Recommendations for persons with failure to DAA treatment have been updated, page 84
- DAA table has been updated, page 85
- DDI table has been updated and now includes BIC, page 86
- Figure on management of acute HCV has been amended, page 87

Opportunistic infections section

- A comment has been added at the beginning of the OI section referring the reader to ART section for timing of ART initiation in individuals with OIs, page 88
- The results of the Reality trial (performed in Africa) added in the cryptococcal disease section in v9.0 has been adapted to European epidemiological settings, page 91
- The treatment induction phase regimen of two weeks of fluconazole 1200 mg/day plus flucytosine for cryptococcal meningitis, has been added as an acceptable alternative regimen in resource-limited settings, page 91
- A comment has been added pointing out the value of JCV-DNA in plasma for PML diagnosis and as a marker of disease progression, page 94
- Screening recommendations for TB have been revised in the assessment table, page 7
- The regimen of daily rifapentine + isoniazid has been added for the treatment of latent TB, page 99

EACS Guidelines are available online at <http://www.eacsociety.org> and in the EACS Guidelines App

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Abbreviations

Antiretroviral drug (ARV) abbreviations				Other abbreviations			
3TC	lamivudine	MVC	maraviroc	ACE	angiotensin converting enzyme	iv	intravenous
ABC	abacavir	NRTI	nucleos(t)ide reverse transcriptase inhibitors	ALP	alkaline phosphatase	IVDU	intravenous drug use
ATV	atazanavir			ALT	alanine aminotransferase	LABA	long-acting β 2-agonist
BIC	bictegravir			aMDRD	abbreviated modification of diet in renal disease formula	LAMA	long-acting muscarinic antagonist
COBI	cobicistat (used as booster=/c)	NNRTI	non-nucleoside reverse transcriptase inhibitors			LDL-c	LDL-cholesterol
d4T	stavudine			ART	antiretroviral therapy	LGV	lymphogranuloma venereum
ddI	didanosine	NVP	nevirapine	AST	aspartate aminotransferase	Mg	magnesium
DRV	darunavir	PI	protease inhibitors	bid	twice daily	MSM	men who have sex with men
DTG	dolutegravir	PI/c	protease inhibitors pharmacologically boosted with cobicistat	BMD	bone mineral density	MTCT	mother to child transmission
EFV	efavirenz			BMI	body mass index	NAFLD	non-alcoholic fatty liver disease
EVG	elvitegravir	PI/r	protease inhibitors pharmacologically boosted with ritonavir	BP	blood pressure	NASH	non-alcoholic steatohepatitis
ENF	enfuvirtide			cART	combination antiretroviral treatment	PAP	papanicolaou test
ETV	etravirine	RAL	raltegravir	CKD	chronic kidney disease	PEG-IFN	pegylated-interferon
FI	fusion inhibitor	RPV	rilpivirine	CKD-EPI	CKD epidemiology collaboration formula	PHI	primary HIV infection
FPV	fosamprenavir	RTV	ritonavir (used as booster=/r)	CMV	cytomegalovirus	po	per oral
FTC	emtricitabine			CNS	central nervous system	PPD	purified protein derivative
IDV	indinavir	SQV	saquinavir	COPD	chronic obstructive pulmonary disease	PPI	proton pump inhibitor
INSTI	integrase strand transfer inhibitor	TAF	tenofovir alafenamide fumarate	CSF	cerebrospinal fluid	PRT	proximal renal tubulopathy
LPV	lopinavir	TDF	tenofovir disoproxil fumarate	CVD	cardiovascular disease	PSA	prostate specific antigen
		TPV	tipranavir	CXR	chest X-ray	PTH	parathyroid hormone
		ZDV	zidovudine	DAA	direct acting antiviral drug	qd	once daily
				DXA	dual energy X-ray absorptiometry	RAS	resistance-associated substitutions
				ECG	electrocardiogram	RBV	ribavirin
				eGFR	estimated glomerular filtration rate	SABA	short-acting β 2-agonist
				FBC	full blood count	SAMA	short-acting muscarinic antagonist
				FRAX	fracture risk assessment tool	sc	subcutaneous
				GT	genotype	SOT	solid organ transplant
				HAV	hepatitis A virus	STI	sexually transmitted infection
				HBV	hepatitis B virus	SVR	sustained virological response
				HCV	hepatitis C virus	TC	total cholesterol
				HDL-c	HDL-cholesterol	TDM	therapeutic drug monitoring
				HEV	hepatitis E virus	TG	triglycerides
				HIVAN	HIV-associated nephropathy	tid	three times daily
				HPV	human papillomavirus	TMP-SMX	trimethoprim-sulfamethoxazole
				HSR	hypersensitivity reaction	UA/C	urine albumin/creatinine ratio
				IGRA	interferon-gamma release assay	UP/C	urine protein/creatinine ratio
				ICS	inhaled corticosteroids	VL	viral load (HIV-RNA)
				IHD	ischaemic heart disease	WB	western blot
				im	intramuscular	Zn	zinc
				IRIS	immune reconstitution inflammatory syndrome		

Part I Assessment of HIV-positive Persons at Initial & Subsequent Visits

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment	See page
HISTORY						
Medical	Complete medical history including:	+	+	First visit	On transfer of care repeat assessment	
	• Family history (e.g. premature CVD, diabetes, hypertension, CKD)	+		First visit	Premature CVD: cardiovascular events in a first degree relative (male < 55, female < 65 years)	42-44, 46-48, 52
	• Concomitant medicines ⁽ⁱ⁾	+	+	Every visit		
	• Past and current co-morbidities	+	+	Every visit		
	• Vaccination history	+		Annual	Measure antibody titres and offer vaccinations where indicated, see Vaccination	
Psychosocial	Current lifestyle (alcohol use, smoking, diet, exercise, drug use)	+	+	6-12 months	Adverse lifestyle habits should be addressed more frequently	41
	Employment	+	+	Every visit	Provide advice and support if needed	
	Social and welfare	+	+		Provide counselling if needed	
	Psychological morbidity	+	+			
	Partner and children	+			Test partner and children if at risk	
Sexual and Reproductive Health	Sexual history	+		6-12 months	Address issues concerning sexual dysfunction	67-69
	Safe sex	+			Risk of sexual transmission should be addressed	
	Partner status and disclosure	+			Recommend starting ART in serodifferent couples	
	Conception issues	+	+			
	Hypogonadism (including menopause)	+	+	As indicated	Persons with complaints of sexual dysfunction	68
HIV DISEASE						
Virology	Confirmation of HIV Ab pos	+		3-6 months	More frequent monitoring of HIV-VL at start of ART	11-16
	Plasma HIV-VL	+	+		Perform genotypic resistance test before starting ART if not previously tested or if at risk of super-infection	
	Genotypic resistance test and sub-type	+	+/-	At virological failure		
	R5 tropism (if available)		+/-		Screen if considering R5 antagonist in regimen	
Immunology	CD4 absolute count and %, CD4/CD8 ratio (optional: CD8 and %)	+	+	3-6 months	Annual CD4 count if stable on ART and CD4 count > 350 cells/μL ⁽ⁱⁱ⁾	11-16
	HLA-B*5701 (if available)	+	+/-		CD4/CD8 ratio is a stronger predictor of serious outcomes	
CO-INFECTIONS						
STIs	Syphilis serology	+		Annual/ as indicated	Consider more frequent screening if at risk	67
	STI screen	+		Annual/ as indicated	Screen if at risk and during pregnancy	
Viral Hepatitis	HAV screen	+		Annual/ as indicated	Screen at risk (e.g. MSM); vaccinate if non-immune	66, 81, 82
	HBV screen	+	+		Annual screen in susceptible persons; vaccinate if non-immune. Use ART containing TDF or TAF in vaccine non-responders	
	HCV screen	+			Annual screen if ongoing risk (e.g. MSM, IVDU) Measure HCV-RNA if HCV Ab pos or if acute infection suspected	
	HEV screen			As indicated	Screen persons with symptoms consistent with acute hepatitis, unexplained flares of aminotransferases or elevated liver function tests, neuralgic amyotrophy, Guillain-Barré, encephalitis or proteinuria. Include anti-HEV IgG and IgM and NAT for HEV-RNA in blood and if possible in stool	81

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment	See page
Tuberculosis	CXR	+		Re-screen if exposure	Consider routine CXR in persons from high TB prevalence populations. Some national guidelines consider the ethnicity, CD4 count and ART usage to define indication for latent tuberculosis infection screening. Use of PPD/IGRA depending on availability and local standard of care. IGRA should, however, be tested before PPD if both are to be used, given the potential for a false positive IGRA after PPD. See Diagnosis and Treatment of TB in HIV-positive Persons	97-99, 18
	PPD	+				
	IGRA in selected high-risk populations (if available)	+				
Others	Varicella zoster virus serology	+			Offer vaccination where indicated	66
	Measles/Rubella serology	+			Offer vaccination where indicated	
	Toxoplasmosis serology	+				
	CMV serology	+				91
	Cryptococcus antigen	+/-			Consider screening for cryptococcus antigen in serum in persons with CD4 count < 100 cells/ μ L	
	Leishmania serology	+/-			Screen according to travel history/origin	
	Tropical screen (e.g. Schistosoma serology)	+/-			Screen according to travel history/origin	
	Influenza virus	+		Annual	In all HIV-positive persons, see Vaccination	66
	<i>Streptococcus pneumoniae</i>	+			No recommendations available regarding the need for a booster dose, see Vaccination	66
	Human papilloma virus	+		As indicated	Vaccinate all HIV-positive persons up to age 26 / age 40 if MSM. If HPV infection is established, efficacy of vaccine is questionable, see Vaccination	66
CO-MORBIDITIES						
Haematology	FBC	+	+	3-12 months		
	Haemoglobinopathies	+			Screen at risk persons	
	G6PD	+			Screen at risk persons	
Body Composition	Body-mass index	+	+	Annual		41
Cardiovascular Disease	Risk assessment (Framingham score ⁽ⁱⁱⁱ⁾)	+	+	2 years	Should be performed in all men > 40 years and women > 50 years without CVD	42
	ECG	+	+/-	As indicated	Consider baseline ECG prior to starting ARVs associated with potential conduction problems	
Hypertension	Blood pressure	+	+	Annual		43-45
Lipids	TC, HDL-c, LDL-c, TG ^(iv)	+	+	Annual	Repeat in fasting state if used for medical intervention (i.e. \geq 8h without caloric intake)	48
Glucose	Serum glucose	+	+	Annual	Consider oral glucose tolerance test / HbA1c if fasting glucose levels of 5.7-6.9 mmol/L (100-125 mg/dL)	46-47
Pulmonary Disease	Respiratory symptoms and risk factors ^(xii)	+	+	Annual	If severe shortness of breath is reported with preserved spirometry, echocardiography may be performed to rule out heart failure and/or pulmonary hypertension	75
	Spirometry			As indicated	Spirometry should be performed in all symptomatic persons ^(xii)	
Liver Disease	Risk assessment ^(v)	+	+	Annual		56-61
	ALT/AST, ALP, Bilirubin	+	+	3-12 months	More frequent monitoring prior to starting and on treatment with hepatotoxic drugs	
	Staging of liver fibrosis			12 months	In HCV and/or HBV co-infected persons (e.g. FibroScan, serum fibrosis markers)	57-58, 81, 84
	Hepatic ultrasound			6 months	Persons with liver cirrhosis ^(xiii)	58, 81, 84
Renal Disease	Risk assessment ^(vi)	+	+	Annual	More frequent monitoring if eGFR < 90mL/min, CKD risk factors present ^(vi) and/or prior to starting and on treatment with nephrotoxic drugs ^(ix)	52-55
	eGFR (CKD-EPI) ^(vii)	+	+	3-12 months		
	Urine dipstick analysis ^(viii)	+	+	Annual	Every 6 months if eGFR < 60 mL/min or rapid decline in eGFR ^(xiv) , if proteinuria \geq 1+ and/or eGFR < 60 mL/min perform UP/C or UA/C ^(viii)	
Bone Disease	Bone profile: calcium, PO ₄ , ALP	+	+	6-12 months		49, 51
	Risk assessment ^(x) (FRAX [®] ^(xi) in persons > 40 years)	+	+	2 years	Consider DXA in specific persons (see page 49 for details)	
Vitamin D	25(OH) vitamin D	+		As indicated	Screen at risk persons	50

	Assessment	At HIV diagnosis	Prior to starting ART	Follow-up frequency	Comment	See page
Neurocognitive Impairment	Screening questionnaire	+	+	As indicated	Screen all persons without highly confounding conditions. If abnormal or symptomatic, see algorithm page 74 for further assessment.	74
Depression	Questionnaire	+	+	As indicated	Screen at risk persons	70-72
Cancer	Mammography			1-3 years	Women 50-70 years	40, 58, 81
	Cervical PAP			1-3 years	HIV-positive women > 21 years or within 1 year after sexual debut	
	Rectal exam and anoscopy			1-3 years	MSM and persons with HPV-associated dysplasia. Evidence of benefit not known	
	Ultrasound and alpha-fetoprotein			6 months	Controversial; persons with cirrhosis and persons with HBV co-infection at high risk of HCC ^(xiii)	
	Others				Controversial	

- i Review all concomitant medicines which may potentially interact with ARVs or increase co-morbidities, see [Drug-drug Interactions between Antidepressants and ARVs](#), [Drug-drug Interactions between Antihypertensives and ARVs](#), [Drug-drug Interactions between Analgesics and ARVs](#), [Drug-drug Interactions between Anticoagulants/Antiplatelet Agents and ARVs](#), [Drug-drug Interactions between Antimalarial Drugs and ARVs](#), [Drug-drug Interactions between Bronchodilators \(for COPD\) and ARVs](#), [Drug-drug Interactions between Immunosuppressants \(for SOT\) and ARVs](#), [Drug-drug Interactions between Pulmonary Antihypertensives and ARVs](#), [Drug-drug Interactions between Corticosteroids and ARVs](#), [Drug-drug Interactions between Contraceptives and ARVs](#), [Drug-drug Interactions between DAAs and ARVs](#) and <http://www.hiv-druginteractions.org>
- ii If stable on ART with undetectable HIV-VL and CD4 count > 350 cells/ μ L, suggest annual CD4 count.
- iii A risk equation developed from HIV populations is available, see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>. Of note, if an individual receives medicines to control dyslipidaemia and/or hypertension, the estimation should be interpreted with caution.
- iv A calculator for LDL-cholesterol in cases where TG is not high can be found at <https://www.mdcalc.com/ldl-calculated>.
- v Risk factors for chronic liver disease include alcohol, viral hepatitis, obesity, diabetes, insulin resistance, hyperlipidaemia and hepatotoxic drugs.
- vi Risk factors for CKD: hypertension, diabetes, CVD, family history, black African ethnicity, viral hepatitis, low current CD4 count, smoking, older age, concomitant nephrotoxic drugs.
- vii eGFR: use CKD-EPI formula based on serum creatinine, gender, age and ethnicity because eGFR quantification is validated > 60 mL/min. The abbreviated modification of diet in renal disease (aMDRD) or the Cockcroft-Gault (CG) equation may be used as an alternative, see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>.
- viii Some experts recommend UA/C (urinary albumin creatinine ratio) or UP/C (urinary protein creatinine ratio) as a screening test for proteinuria in all persons. UA/C predominantly detects glomerular disease. Use in persons with diabetes. UP/C detects total protein secondary to glomerular and tubular disease.
- ix Different models have been developed for calculating a 5-year CKD risk score while using different nephrotoxic ARVs, integrating HIV independent and HIV-related risk factors [6], [7].
- x Classic risk factors: older age, female gender, hypogonadism, family history of hip fracture, low BMI (≤ 19 kg/m²), vitamin D deficiency, smoking, physical inactivity, history of low impact fracture, alcohol excess (> 3 units/day), steroid exposure (minimum 5 mg for > 3 months).
- xi WHO fracture risk assessment (FRAX®) tool: <http://www.shef.ac.uk/FRAX>.
- xii Respiratory symptoms: shortness of breath, chronic cough and sputum. Risk factors: tobacco, occupation, in- and outdoor pollution and host factors including previous PCP or TB, recurrent pneumonia and Alpha-1 antitrypsin deficiency. A diagnosis of COPD should be considered in persons over the age of 35 years who have a risk factor (current or ex-smoker) and who present with exertional breathlessness, chronic cough, regular sputum production, frequent winter 'bronchitis' or wheeze.
- xiii HCC screening is indicated in all cirrhotic HBV or HCV co-infected persons (even if HCV infection has been cured and HBV replication is medically suppressed) in a setting where treatment for HCC is available. Although the cost-effectiveness of HCC screening in persons with F3 fibrosis* is uncertain, surveillance may be considered based on an individual risk assessment (<http://www.easl.eu/research/our-contributions/clinical-practice-guidelines/detail/easl-clinical-practice-guidelines-on-hepatocellular-carcinoma>). In HBV-positive non-cirrhotics, HCC screening should follow current EASL guidelines. Risk factors for HCC in this population include family history of HCC, ethnicity (Asians, Africans), HDV and age. EASL guidelines propose using the PAGE-B score in Caucasians to assess the HCC risk, however this score has not been validated in HIV-positive persons.
- * F4 diagnosis made by transient elastography measurement should be validated by a biomarker score, signs of cirrhosis in liver in sonography or at least repetition of transient elastography after 6 months. F3 diagnosis made by transient elastography measurement should be confirmed by a second measurement after 6 months. Cut-offs for F4 (cirrhosis): 13.0 kPa, for F3: 10.0 kPa (<http://easl.eu/research/our-contributions/clinical-practice-guidelines/detail/easl-recommendations-on-treatment-of-hepatitis-c-2018>).

Part II ART of HIV-positive Persons

This section provides an overview of the important aspects of the management of HIV-positive individuals starting or established on ART. Recommendations are based on a range of evidence, in particular it is weighted towards randomised controlled clinical trials. Other data have been taken into account, including cohort studies, and where evidence is limited the panel has reached a consensus around best clinical practice. The ART section is wide ranging and, with the move to starting therapy independently of CD4 count, there is an important section on readiness to start. Treatment recommendations are based on drugs licensed in Europe and range from initial therapy through to switching with or without virological failure. We highlight two important areas of ART: pregnancy and TB. Details on the use of PrEP, which is being rolled out across Europe, are also included. Finally, with the increasing complexity of co-morbidities and concomitant treatments, a large part of the section is devoted to adverse effects, drug interactions and dose adjustments in renal and hepatic disease.

Assessing HIV-positive Persons' Readiness to Start and Maintain ART^(x)

Goal: to help persons start and/or maintain ART	
<p>The equipoise when to start ART has changed in light of the START trial [1]. Evidence is accumulating that starting ART on the same day after establishing a diagnosis of HIV infection is feasible and acceptable to HIV-positive persons. Nevertheless, assessment of the readiness to start ART is essential to enable the HIV-positive person to express their preference and not feel pressured to start ART immediately, unless clinically indicated.</p> <p>Successful ART requires a person's readiness to start and adhere to the regimen over time. The trajectory from problem awareness to maintenance on ART can be divided into five stages. Knowing a person's stage, health care providers use appropriate techniques to assist them to start and maintain ART.</p>	<p>Identify the person's stage of readiness using WEMS⁽ⁱ⁾ techniques, and start discussion with an open question/invitation: "I would like to talk about HIV medicines." <wait> "What do you think about them?"</p> <p>Based on the person's response, identify his/her stage of readiness and intervene accordingly⁽ⁱⁱ⁾</p> <p>Immediate (same day) start of ART should be considered, especially in the following situations:</p> <ul style="list-style-type: none"> - In the setting of primary HIV infection, especially in case of clinical signs and symptoms of meningoencephalitis (within hours). In this situation, the clinician may start ART immediately after a positive screening HIV test and before obtaining confirmatory HIV test results such as a HIV-VL. - The wish of an HIV-positive person to start ART immediately. - In a setting where loss-to-follow-up is more likely if ART is not started the same day.
Stages of readiness to start ART	
<p>Precontemplation: "I don't need it, I feel good." "I don't want to think about it."</p>	<p>Support: Show respect for the person's attitude. / Try to understand the person's health and therapy beliefs. / Establish trust. / Provide concise, individualised information. / Schedule next appointment.</p>
<p>Contemplation: "I am weighing things up and feel torn about what to do about it."</p>	<p>Support: Allow ambivalence. / Support the person in weighing pros and cons. / Assess the person's information needs and support his/her information seeking. / Schedule the next appointment.</p>
<p>Preparation: "I want to start, I think the drugs will allow me to live a normal life."</p>	<p>Support: Reinforce the person's decision. / Decide with the person which is the most convenient regimen. / Educate the person on adherence, resistance and side effects. / Discuss integration into daily life. / Assess self-efficacy.</p> <p>Ask: How confident are you that you can take your medicines as we discussed (specify) once you have started? Use VAS 0-10⁽ⁱⁱⁱ⁾</p> <p>Consider skills training:</p> <ul style="list-style-type: none"> • Medicines-taking training, possibly Medication Event Monitoring System, e.g. electronic pill boxes • Directly observed therapy with educational support • Use aids: mobile phone alarm, pillboxes • Involve supportive tools/persons where appropriate
<p>Action: "I will start now."</p>	<p>'Final check': With a treatment plan established, is the person capable of taking ART and is ART available?</p>
<p>Maintenance: "I will continue." or "I have difficulties continuing over the long run."</p> <p>Caveat: A person can relapse to an earlier stage, even from "maintenance" to "precontemplation"</p>	<p>Assess: Adherence every 3-6 months^(iv)</p> <p>Evaluate adherence: For persons with good adherence: show respect for their success.</p> <p>Assess: The person's own perception of ability to adhere to and continue treatment.</p> <p>Ask: In the next 3-6 months, how confident are you that you can take your medicines? Use VAS 0-10⁽ⁱⁱⁱ⁾</p> <p>For a person without sufficient adherence: use mirroring techniques^(v) on problems, ask open questions to identify dysfunctional beliefs.</p> <p>Assess: Stage of readiness and provide stage-based support</p> <p>Assess: Barriers and facilitators^(vi)</p> <p>Schedule next appointment and repeat support</p>

Several barriers are known to influence ART decision making and adherence to ART	
Screen for and talk about problems and facilitators	
Consider systematic assessment of: <ul style="list-style-type: none"> • Depression^(vii), see page 70-71 • Cognitive problems^(viii), see page 74 • Harmful alcohol^(ix) or recreational drug use, see page 39, 41 	Consider talking about: <ul style="list-style-type: none"> • Social support and disclosure • Health insurance and continuity of drug supply • Therapy-related factors
Recognise, discuss and reduce problems wherever possible in a multidisciplinary team approach.	

- i WEMS: Waiting (> 3 sec), Echoing, Mirroring, Summarising [2]
- ii The person presenting in the clinic may be at different stages of readiness: precontemplation, contemplation or preparation. The first step is to assess the stage, and then to support/intervene accordingly. In the case of late presentation (CD4 count < 350 cells/ μ L), the initiation of ART should not be delayed. The person should be closely followed and optimally supported. Schedule the next appointment within a short time, i.e. 1-2 weeks.
- iii VAS (= Visual Analogue Scale; range from 0 to 10, i.e. 0= I will not manage, 10= I am sure I will manage).



- iv Suggested adherence questions: "In the past 4 weeks how often have you missed a dose of your HIV medicines: every day, more than once a week, once a week, once every 2 weeks, once a month, never?" / "Have you missed more than one dose in a row?" [3].
- v Mirroring: reflecting back on what a person has said or non-verbally demonstrated (e.g. anger or disappointment) WITHOUT introducing new material by asking questions or giving information.
- vi Adherence to long-term therapies [4].
- vii PHQ-2 or PHQ-9 [5]. Meta-analysis shows a consistent relationship between depression and ART non-adherence that is not limited to those with clinical depression. Therefore, assessment and intervention aimed at reducing depressive symptom severity, even at subclinical level is important. Ask: "Over the last two weeks, how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things; 2. Feeling down, depressed or hopeless." Answers: Not at all (0) / Several days (1) / More than half the days (2) / Nearly every day (3). If the person scores 2 or more, seven additional questions, see [6].
- viii Ask: "Do you feel having problems to concentrate in your daily life?" / "Do you feel slowed in your thinking?" / "Do you feel having problems with your memory?" / "Did relatives or friends express that they feel you have problems with your memory or difficulty concentrating?" [7].
- ix FAST-alcohol use, ask: How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? Never=0, Less than monthly=1, Monthly=2, Weekly=3, Daily or almost daily=4. Stop if the answer is 0 (Never). Ask more questions if the answer is 1, 2, 3 or 4. See [8].
- x Algorithm adapted from [9].

Recommendations for Initiation of ART in HIV-positive Persons with Chronic Infection without prior ART Exposure

Recommendations take into account the level of evidence, the degree of progression of HIV disease and the presence of, or high risk for, developing various types of (co-morbid) conditions.

ART is recommended in all adults with chronic HIV infection, irrespective of CD4 counts⁽¹⁾

- i ART should always be recommended irrespective of the CD4 count, but the lower the CD4 count, the greater the urgency to start ART immediately. Use of ART should also be recommended at any CD4 count in order to reduce sexual transmission MTCT of HIV (before third trimester of pregnancy).
- In persons with OIs, it is recommended to initiate ART during the two weeks following the diagnosis. The exception is cryptococcal meningitis, in which delaying ART until four weeks of antimicrobial therapy is advised, due to the risk of life-threatening IRIS. For ART initiation in persons with TB, see page 18.
 - A possible exception could be persons with high CD4 counts and HIV-VL < 1000 copies/mL, although even in such persons ART initiation has been shown to increase CD4 count, dampen inflammation and lower the risk of emerging infection with higher HIV-VL.
 - Genotypic resistance testing is recommended prior to initiation of ART, ideally at the time of HIV diagnosis; otherwise before initiation of ART.
 - If ART needs to be initiated before genotypic testing results are available, it is recommended to include a drug with a high genetic barrier to resistance in the first-line regimen (e.g. a PI/r, PI/c, DTG or BIC). Ideally, before starting treatment, the HIV-VL level and CD4 count should be repeated to more reliably assess the infection status and subsequent response to ART.

Initial Combination Regimen for ART-naïve Adult HIV-positive Persons

Out of the recommended regimens in persons starting ART, we recommend the use of an INSTI as preferred third agent; tailoring antiretroviral regimens for each individual is essential as other classes of third agents (e.g boosted PI) might be indicated in the presence of resistance or risk of poor adherence.

A) Recommended regimens (one of the following to be selected)*, **

* Only drugs currently licensed for initiation of therapy by the EMA are taken into consideration (in alphabetical order).

** Generic HIV drugs are becoming more available and can lead to large cost savings. They can be used as long as they replace the same drug and do not break recommended fixed dose combinations

Regimen	Dosing	Caution	Food requirement
2 NRTIs + INSTI			
ABC/3TC/DTG ^(i, ii, x)	ABC/3TC/DTG 600/300/50 mg, 1 tablet qd	Al/Ca/Mg-containing antacids or multivitamins should be taken well separated in time (minimum 2h after or 6h before). DTG 50 mg bid with rifampicin.	None
TAF/FTC ⁽ⁱⁱⁱ⁾ or TDF/FTC ⁽ⁱⁱⁱ⁾ + DTG ^(x)	TAF/FTC 25/200 mg, 1 tablet qd or TDF/FTC 300/200 mg, 1 tablet qd + DTG 50 mg, 1 tablet qd	Al/Ca/Mg-containing antacids should be taken 2h after BIC (fasting conditions) whereas Ca, Mg, Fe or multivitamins supplements can be administered simultaneously with food.	None
TAF/FTC/BIC ^(iv)	TAF/FTC/BIC 25/200/50 mg, 1 tablet qd	Co-administration of antacids containing Al or Mg not recommended. Co-administration of RAL 1200 mg qd with Ca containing antacids or with Ca, Mg, Fe supplements is not recommended. Use RAL 400 mg bid instead. RAL ^(iv) 400 or 800 mg bid with rifampicin.	None
TAF/FTC ⁽ⁱⁱⁱ⁾ or TDF/FTC ⁽ⁱⁱⁱ⁾ + RAL ^(iv)	TAF/FTC 25/200 mg, 1 tablet qd or TDF/FTC 300/200 mg, 1 tablet qd + RAL 600 mg, 2 tablets qd or + RAL 400 mg, 1 tablet bid		None
2 NRTIs + NNRTI			
TAF/FTC/RPV ⁽ⁱⁱⁱ⁾ or TDF/FTC/RPV ⁽ⁱⁱⁱ⁾	TAF/FTC/RPV 25/200/25 mg, 1 tablet qd or TDF/FTC/RPV 300/200/25 mg, 1 tablet qd	Only if CD4 count > 200 cells/ μ L and HIV-VL < 100,000 copies/mL. PPI contraindicated; H2 antagonists to be taken 12h before or 4h after RPV.	With food
2 NRTIs + PI/r or PI/c			
TAF/FTC ⁽ⁱⁱⁱ⁾ or TDF/FTC ⁽ⁱⁱⁱ⁾ + DRV/c ^(v) or + DRV/r ^(v)	TAF/FTC 10/200 mg, 1 tablet qd or TDF/FTC 300/200 mg, 1 tablet qd + DRV/c 800/150 mg, 1 tablet qd or + DRV 800 mg, 1 tablet qd + RTV 100 mg, 1 tablet qd or TAF/FTC/DRV/c 10/200/800/150 mg, 1 tablet qd	Monitor in persons with a known sulfonamide allergy.	With food

B) Alternative regimens (to be used when none of the preferred regimens are feasible or available, whatever the reason)

Regimen	Dosing	Caution	Food requirement
2 NRTIs + INSTI			
ABC/3TC ^(i, ii) + RAL ^(iv)	ABC/3TC 600/300 mg, 1 tablet qd + RAL 600 mg, 2 tablets qd or + RAL 400 mg, 1 tablet bid	Co-administration of antacids containing Al or Mg not recommended. Co-administration of RAL 1200 mg qd with high dose Ca not recommended. RAL ^(iv) 400 or 800 mg bid with rifampicin.	None
TAF/FTC/EVG/c ^(iii, vi) or TDF/FTC/EVG/c ^(iii, vi)	TAF/FTC/EVG/c 10/200/150/150 mg, 1 tablet qd or TDF/FTC/EVG/c 300/200/150/150 mg, 1 tablet qd	Al/Ca/Mg-containing antacids or multivitamins should be taken well separated in time (minimum 2h after or 6h before).	With food
2 NRTIs + NNRTI			
ABC/3TC ^(i, ii) + EFV ^(vii)	ABC/3TC 600/300 mg, 1 tablet qd + EFV 600 mg, 1 tablet qd	Only if HIV-VL < 100,000 copies/mL.	At bed time or 2 hours before dinner
TDF/FTC/EFV ^(iii, viii)	TDF/FTC/EFV 300/200/600 mg, 1 tablet qd		
2 NRTIs + PI/r or PI/c			
ABC/3TC ^(i, ii) + ATV/c ^(viii, ix) or + ATV/r ^(viii, ix)	ABC/3TC 600/300 mg, 1 tablet qd + ATV/c 300/150 mg 1 tablet qd or + ATV 300 mg, 1 tablet qd + RTV 100 mg, 1 tablet qd	Only if HIV-VL < 100,000 copies/mL.	With food
ABC/3TC ^(i, ii) + DRV/c ^(v) or + DRV/r ^(v)	ABC/3TC 600/300 mg, 1 tablet qd + DRV/c 800/150 mg, 1 tablet qd or + DRV 800 mg, 1 tablet qd + RTV 100 mg, 1 tablet qd	Monitor in persons with a known sulfonamide allergy.	With food
TAF/FTC ⁽ⁱⁱⁱ⁾ or TDF/FTC ⁽ⁱⁱⁱ⁾ + ATV/c ^(viii, ix) or + ATV/r ^(viii, ix)	TAF/FTC 10/200 mg 1 tablet qd or TDF/FTC 300/200 mg, 1 tablet qd + ATV/c 300/150 mg, 1 tablet qd or + ATV 300 mg, 1 tablet qd + RTV 100 mg, 1 tablet qd		With food
Other combinations			
[DTG ^(x) + 3TC] ^(ii, xii)	DTG 50 mg, 1 tablet qd + 3TC 300 mg, 1 tablet qd	Al/Ca/Mg-containing antacids or multivitamins should be taken well separated in time (minimum 2h after or 6h before). Only if HIV-VL < 500,000 copies/mL	None
[RAL + DRV/c ^(v) or + DRV/r ^(v)] ⁽ⁱⁱ⁾	RAL 400 mg, 1 tablet bid + DRV/c 800/150 mg, 1 tablet qd or + DRV 800 mg, 1 tablet qd + RTV 100 mg, 1 tablet qd	Only if CD4 count > 200 cells/ μ L and HIV-VL < 100,000 copies/mL. Co-administration of antacids containing Al or Mg not recommended.	With food

i ABC contraindicated if HLA-B*5701 positive. Even if HLA-B*5701 negative, counselling on HSR risk still mandatory. ABC should be used with caution in persons with a high CVD risk (> 20%).

ii Use this combination only if HBsAg-negative.

iii In certain countries TDF is labelled as 245 mg to reflect the concentration of the prodrug (tenofovir disoproxil). There are available generic forms of TDF, which instead of fumarate use phosphate, maleate, and succinate salts. They can be used interchangeably. When available, combinations containing TDF can be replaced by the same combinations containing TAF. TAF is used at 10 mg when co-administered with drugs that inhibit P-gp, and at 25 mg when co-administered with drugs that do not inhibit P-gp.

The decision whether to use TDF or TAF depends on individual characteristics as well as availability. So far, there are only limited long-term data on TAF.

If the ART regimen does not include a booster, TAF and TDF have a similar short-term risk of renal adverse events leading to discontinuation and bone fractures.

TAF*** should be considered as a first choice**** over TDF in individuals with:

- established or high risk of CKD, see page 52;
- co-medication with nephrotoxic drugs or prior TDF toxicity, see page 53;
- osteoporosis / progressive osteopenia or risk factors, see page 49;
- history of fragility fracture, see page 51.

*** There are limited data on use of TAF with eGFR < 30 mL/min; **** Expert opinion pending clinical data.

iv No data on RAL 1200 mg with rifampicin, co-administration not recommended; No data on RAL 1200 mg in pregnancy: not recommended.

v A single study has shown increase in CVD risk with cumulative use of DRV [13].

vi TDF/FTC/EVG/c and TAF/FTC/EVG/c are alternative treatments: within INSTI class, booster free regimens with equal efficacy are preferred.

TDF/FTC/EVG/c to be used only if eGFR \geq 70 mL/min. It is recommended that TDF/FTC/EVG/c is not initiated in persons with eGFR < 90 mL/min unless this is the preferred treatment.

vii EFV: not to be given if history of suicide attempts or mental illness; not active against HIV-2 and HIV-1 group O strains.

viii Co-administration of PPI is contraindicated. If PPI co-administration is judged unavoidable, consider an alternative regimen; if given, dose increase of ATV to 400 mg qd may be considered, close clinical monitoring is recommended and doses of PPI comparable to omeprazole 20 mg should not be exceeded and must be taken approximately 12 hours prior to the ATV/r. H2 antagonists to be taken 12 hours before or 4 hours after ATV.

ix Potential renal toxicity with ATV/r and ATV/c.

x DTG should not be prescribed to women seeking to become pregnant; women who can become pregnant should use effective contraception while taking DTG.

xi Reduced exposure of TAF/FTC/BIC with rifampicin, co-administration not recommended. No data on TAF/FTC/BIC in pregnancy: not recommended.

xii 2 large RCTs at 48 weeks have shown non-inferiority of DTG and 3TC dual therapy vs triple therapy in treatment-naïve persons with wild-type virus. It is considered that longer follow-up beyond 48 weeks is needed before this dual regimen is selected as "recommended".

Primary HIV Infection (PHI)

Definition of PHI^(i-iv)

- High-risk exposure within previous 6 months, and
- Detectable virus in plasma (p24 Ag and/or HIV-RNA) and/or
- Evolving anti-HIV antibody reactivity (negative or indeterminate to positive)
- With (23-92%) or without clinical symptoms.

Classification of PHI^(i-iv)

- Acute infection: HIV detection (p24 Ag and/or HIV-RNA) in the absence of HIV antibody.
- Recent infection: HIV antibody detection; up to 6 months after infection.

Starting treatment^(v-vi)

Treatment of PHI is recommended for all HIV-positive persons. Several circumstances indicate immediate treatment initiation.

Circumstances where immediate treatment initiation should be advised

Acute infection
Severe or prolonged symptoms
Neurological disease
Age ≥ 50 years
CD4 count < 350 cells/μL
Pregnancy

The recommendation is based on:

- Demonstrated virological and immunological benefits and anticipated clinical benefits of early therapy^(v)
- Reduced risk of transmission
- Usually short interval between identification of PHI and a CD4 count < 500 cells/μL
- Reduced anxiety and facilitated disclosure to contacts

The HIV-positive person must be willing to take therapy and counselling should promote engagement by emphasising the benefits of starting treatment early. The HIV-positive person should also be made aware of the potential disadvantages of early treatment^(vi).

Asymptomatic persons with PHI with a recent infection and a preserved CD4 count who decide to defer therapy should enter follow-up according to the guidance outlined for established (chronic) infection.

Once treatment is started, it should be continued. A subsequent interruption is not recommended.

Treatment selection

- The HIV-positive person should preferably be recruited into a clinical trial or studies investigating HIV curative strategies.
- Any use of pre-exposure or post-exposure prophylaxis should be identified and taken into account when choosing the initial regimen.
- A drug resistance test is recommended in all cases as soon as possible after diagnosis. A genotypic (rather than phenotypic) test is recommended due to increased sensitivity and wide availability.
- Where there are indications for immediate treatment (see table), therapy may have to start before the results of resistance testing become available. Whilst evidence is evolving, current guidance remains that in such cases preference should be given to starting a PI/r or PI/c in order to increase the barrier to resistance of the overall regimen. An INSTI should also be included in order to induce rapid viral load suppression. A combination of TDF or TAF, FTC, and either boosted DRV, or an INSTI should therefore be considered, and the regimen adjusted, if needed, once the resistance test becomes available and viral load suppression is achieved. Where such a regimen is not available, national epidemiological data on prevalence and patterns of transmitted drug resistance (where available and sufficiently representative) may assist with the treatment selection process.

Other considerations

- All HIV-positive persons should undergo investigations to diagnose sexually transmitted infections (e.g. syphilis, gonorrhoea, chlamydia), HBV and HCV. Antibody seroconversion can be delayed and tests to identify the viral RNA are required in order to identify a recent HCV infection.
- All HIV-positive women of reproductive age should have a pregnancy test.
- All HIV-positive persons should be counselled about the high risk of transmission, preventive measures, and importance of notifying partners.
- i HIV-1 RNA becomes detectable in plasma around day 11 after exposure, approximately 7 days before p24 Ag and 12 days before anti-HIV antibodies.
- ii Where available, Western Blot (WB) or Immunoblot patterns of reactivity can be used to stage the infection as follows [12];
- Stage I: HIV-RNA positive only (average duration 5 days). HIV-VL levels are median 2,000 copies/mL (IQR 300-20,000 copies/mL), and are < 100 copies/mL in approximately 10% of HIV-positive persons. Low HIV-VL levels should be interpreted with caution due to the risk of false positivity (e.g., due to contamination)
- Stage II: HIV-RNA and p24 Ag positive only (average duration 5.3 days). NB: HIV-VL levels are usually > 10,000 copies/mL
- Stage III: HIV-RNA, p24 Ag and anti-HIV antibody positive by immunoassay, no specific WB bands (average duration 3.2 days)
- Stage IV: as Stage III but indeterminate WB pattern (5.6 days)
- Stage V: as Stage III, but reactive WB pattern lacking p31 reactivity (average duration 69.5 days)
- Stage VI: as stage III but full WB reactivity including a p31 band (indefinite)
- iii Everyone with detectable HIV-VL and negative or indeterminate serology must receive confirmation of anti-HIV antibody seroconversion in follow-up testing. The interval of testing (up to stage V) is one week.
- iv Some centres may have access to sero-incidence markers (e.g., antibody avidity testing) that identify an infection acquired within the previous 3-6 months. Assay reliability varies and results should be interpreted with caution when they are the sole indicators of a recent infection.
- v Potential benefits of treatment: reduce severity of acute symptoms; lower the HIV-VL set-point and size of the viral reservoir; reduce viral genetic evolution; reduce immune activation and inflammation; preserve immune function and integrity of lymphoid tissue; possibly exert neurological and gut protection; possibly enhance post-treatment control and response to future eradication strategies. These effects are more likely if treatment is started in the acute phase of PHI.
- vi Potential disadvantage of treatment: firm, controlled evidence that treatment of PHI results in clinical benefit in the long-term (relative to starting therapy past the PHI stage) is currently lacking. Data supporting immediate treatment are mostly derived from persons with symptomatic PHI. Low likelihood of post-treatment control; treatment interruption usually leads to rebound of HIV-VL and inflammation markers; possible adverse consequences of long-term ART (toxicity, drug resistance). A small subset of HIV-positive persons can spontaneously control the infection without treatment (elite controllers).

See online video lectures [When to start ART-Part 1](#), [When to start ART-Part 2](#), [What ART to start-Part 1](#) and [What ART to start-Part 2](#) from the EACS online course on Clinical Management of HIV.

Switch Strategies for Virologically Suppressed Persons

Definition of virologically suppressed

Clinical trials exploring switching strategies have defined suppression as an HIV-VL < 50 copies/mL for at least 6 months.

Indications

1. **Documented toxicity** caused by one or more of the antiretrovirals included in the regimen. Examples of these reactive switches: lipoatrophy (d4T, AZT), central nervous system adverse events (EFV), diarrhoea (PI/r) and jaundice (ATV), proximal renal tubulopathy and low bone mineral density (TDF), see [Adverse Effects of ARVs and Drug Classes](#).
2. **Prevention of long-term toxicity**. Example of this proactive switch: prevention of lipoatrophy in persons receiving d4T or AZT and prevention of proximal renal tubulopathy with TDF, see [Adverse Effects of ARVs and Drug Classes](#).
3. **Avoid serious drug-drug interactions**
4. **Planned pregnancy**
5. **Ageing and/or co-morbidity** with a possible negative impact of drug(s) in current regimen, e.g. on CVD risk, metabolic parameters.
6. **Simplification**: to reduce pill burden, adjust food restrictions and improve adherence.
7. **Starting of HCV treatment in case of drug-drug interaction**, see [Drug-drug Interactions between DAAs and ARVs](#).

Principles

Clinicians should always review possible adverse events or tolerability issues with current antiretroviral regimens. Just because the HIV-VL is suppressed it should not be assumed that the HIV-positive person is well adapted and tolerating the current regimen.

1. The objectives of treatment modification should be to eliminate or improve adverse events, facilitate adequate treatment of co-morbid conditions, and improve quality of life.
2. The primary concern when switching should be to sustain and not to jeopardize virological suppression. In persons without prior virological failures and no archived resistance, switching regimens entail a low risk of subsequent failure if clinicians select one of the recommended combinations for first-line therapy. The majority of clinical trials showing non-inferiority of the new regimen after the switch have actively excluded persons with prior virological failures.
3. A complete ARV history with HIV-VL, tolerability issues and cumulative genotypic resistance history should be analysed prior to any drug switch.
4. A PI/r or PI/c may be switched to unboosted ATV, an NNRTI, or an INSTI only if full activity of the 2 NRTIs remaining in the regimen can be guaranteed. Switches have to be planned especially carefully when they result in a decrease in the genetic barrier of the regimen in case of prior virologic failures. Clinicians should review the complete ARV history and available resistance test and HIV-VL results before switching, and ensure no drug-drug interactions may lead to suboptimal drug levels (e.g. unboosted ATV and TDF).

5. Before switching, remaining treatment options in case of potential virological failure of the new regimen should be taken into consideration. For example, the development of the M184V RT mutation in HIV-positive persons who fail a 3TC-containing regimen might preclude the future use of all currently available single-tablet regimens.
6. Switches of single drugs with the same genetic barrier (for example EFV to RAL) is usually virologically safe in the absence of resistance to the new compound.
7. When selecting a new regimen, clinicians should carefully review the possibility of new drug-drug interactions with antiretroviral and concomitant medication, as well as the lag time for hepatic enzyme induction or blockade following discontinuation of the offending drug.
8. If the switch implies discontinuing TDF and not starting TAF, clinicians should check the HBV status (avoid discontinuation of TDF in persons with chronic HBV and assess HBV vaccination status).
9. HIV-positive persons should be seen soon (e.g. 4 weeks) after treatment switches to check for maintenance of suppression and possible toxicity of the new regimen.
10. If a HIV-positive person receives and tolerates a regimen that is no longer a preferred option, there is no need to change. Example: persons tolerating EFV-containing regimens.
11. See online video lecture [How to Change ART](#) from the EACS online course Clinical Management of HIV.

Class-sparing strategies

Dual therapy:

DTG + RPV
3TC + (DRV/r or DRV/c) or
3TC + (ATV/r or ATV/c)

In clinical trials these strategies have not been associated with more virological rebounds than triple therapy.

Monotherapy with DRV/r:

In clinical trials this strategy has been associated with more virological rebounds than triple therapy. DRV/r monotherapy is an option only for exceptional persons who are not candidates for dual therapies.

In persons with suppression of HIV-VL < 50 copies/mL for the past 6 months dual therapy with 3TC + PI/r or PI/c should only be given if there is a) no resistance and b) absence of chronic HBV co-infection. The same applies to DRV/r monotherapy.

Strategies not recommended

- a. Monotherapy with ATV/r
- b. Monotherapy with DTG
- c. Triple NRTIs combinations
- d. Specific two-drug combination, i.e. 1 NRTI + 1 NNRTI or 1 NRTI + 1 unboosted PI, 1 NRTI + RAL, 2 NRTIs, MVC + RAL, PI/r or PI/c + MVC, ATV/r or ATV/c + RAL
- e. Intermittent therapy, sequential or prolonged treatment interruptions

Virological Failure

Definition	INCOMPLETE SUPPRESSION: HIV-VL > 200 copies/mL at 6 months ⁽ⁱ⁾ after starting therapy in persons not previously on ART. REBOUND: confirmed HIV-VL > 50 copies/mL in persons with previously undetectable HIV-VL.
General measures	<p>Review expected potency of the regimen</p> <p>Evaluate adherence, compliance, tolerability, drug-drug interactions, drug-food interactions, psychosocial issues</p> <p>Perform resistance testing on failing therapy (usually routinely available for HIV-VL levels > 350-500 copies/mL and in specialised laboratories for lower levels of viraemia) and obtain historical resistance testing for archived mutations</p> <p>Tropism testing</p> <p>Consider TDM</p> <p>Review ART history</p> <p>Identify treatment options, active and potentially active drugs/combinations</p>
Management of virological failure (VF)	<p>If HIV-VL > 50 and < 500 copies/mL:</p> <p>Check for adherence</p> <p>Check HIV-VL 1 to 2 months later</p> <p>If genotype not possible, consider changing regimen based on past treatment and resistance history</p> <p>If HIV-VL confirmed > 500 copies/mL:</p> <p>Change regimen as soon as possible. What to change will depend on the resistance testing results:</p> <p>If no resistance mutations found: re-check for adherence, perform TDM</p> <p>If resistance mutations found: switch to a suppressive regimen based on drug history; multidisciplinary expert discussion advised</p> <p>Goal of new regimen: HIV-VL < 50 copies/mL within 6 months</p>

In case of demonstrated resistance mutations	<p>General recommendations:</p> <p>Use at least 2 and preferably 3 active drugs in the new regimen (including active drugs from previously used classes) based on resistance mutations present in current and earlier genotypic analyses</p> <p>Any regimen should use at least 1 fully active boosted PI (e.g. DRV/r) plus 1 drug from a class not used previously e.g. INSTI, FI, or CCR5 antagonist (if tropism test shows R5 virus only), or 1 NNRTI (e.g. ETV), assessed by genotypic testing.</p> <p>Alternatively, a regimen can be constructed with DTG (when fully active) plus 2 NRTIs, of which at least 1 NRTI is fully active.</p> <p>Defer change if < 2 active drugs available, based on resistance data, except in persons with low CD4 count (< 100 cells/μL) or with high risk of clinical deterioration for whom the goal is the preservation of immune function through partial reduction of HIV-VL (> 1*log₁₀ reduction) by recycling</p> <p>If limited options, consider experimental and new drugs, favouring clinical trials (but avoid functional monotherapy)</p> <p>Treatment interruption is not recommended</p> <p>Consider continuation of 3TC or FTC in particular situations even if documented resistance mutation (M184V/I)</p> <p>If many options are available, criteria of preferred choice include: simplicity of the regimen, toxicity risks evaluation, drug-drug interactions, and future salvage therapy</p>
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ⁱ In persons with very high baseline HIV-VL (> 100,000-500,000 copies/mL) achieving viral suppression may take longer than 6 months.

See online video lecture [Adherence and Prevention of HIV Drug Resistance](#) from the EACS online course Clinical Management of HIV.

Treatment of HIV-positive Pregnant Women

Pregnant women should be monitored every month and as close as possible to the predicted delivery date

Criteria for starting ART in pregnant women (see different scenarios)	Same as for non-pregnant
Objective of treatment in pregnant women	Full plasma HIV-VL suppression at least by third trimester and specifically at time of delivery. In such instance, risk of transmission is 0 to < 0.5%
Resistance testing	Same as for non-pregnant women, i.e. before starting ART and in case of virological failure
SCENARIO	
1. Women planning to be pregnant while already on ART	1. Maintain ART, unless taking some contraindicated regimen during pregnancy (DTG in the first trimester, ddi + d4T, triple NRTI combinations)
2. Women becoming pregnant while already on ART	2. Maintain ART, unless taking some contraindicated regimen during pregnancy (DTG in the first trimester, ddi + d4T, triple NRTI combinations)
3. Women becoming pregnant while treatment-naïve	3. Starting ART as soon as possible is highly recommended
4. Women whose follow-up starts late in the second or in the third trimester	4. Start ART immediately and consider RAL as the preferred choice to obtain rapid HIV-VL decline and to ensure the HIV-VL is undetectable by the time of delivery
5. Women whose HIV-VL is not undetectable at third trimester	5. Perform resistance testing and consider changing to or adding INSTI (RAL or DTG) if not on this class to obtain rapid HIV-VL decline
Antiretroviral regimen in pregnancy	<p>Same as non-pregnant</p> <p>If on RAL (400 mg bid), RPV or DRV/r: could be continued No data on RAL 1200 mg qd: not recommended Women on EVG/c need to be informed that more monitoring of HIV-VL and drug levels may be necessary during pregnancy Women on DTG need to be switched to a different third agent, at least for the first trimester (evidence of increased risk of neural tube defect in newborns exposed to DTG from one observational cohort)</p> <p>Among PI/r, prefer ATV/r RTV is the recommended booster for women on treatment with boosted PI during pregnancy DRV/c is not recommended during pregnancy due to significant lower exposures of DRV and COBI in the second and third trimester of pregnancy</p> <p>EFV is a suitable alternative for pregnant persons needing to start treatment. It can be continued if already started before pregnancy NVP not to be initiated, but continuation is possible if started before pregnancy Limited experience with TAF in pregnancy: not recommended in initial regimen No experience with BIC in pregnancy: not recommended</p>
Drugs contraindicated during pregnancy	DTG (first trimester), ddi + d4T, triple NRTI combinations
iv ZDV during labour	Only if HIV-VL > 50 copies/mL at week 34-36
Single dose NVP during labour	Not recommended
Caesarean section	Only if HIV-VL > 50 copies/mL at week 34-36
Breastfeeding	We advise against breastfeeding. In case a woman insists on breastfeeding, we recommend follow-up with increased clinical and virological monitoring of both the mother and the infant

ART in TB/HIV Co-infection

Principles

Persons with TB should be started on standard TB therapy with 2 months rifampicin/isoniazid/pyrazinamide/ethambutol followed by 4 months rifampicin/isoniazid (choice of drugs and length of treatment depends on drug susceptibility and site of disease), see [Diagnosis and Treatment of TB in HIV-positive Persons](#)

All persons with TB/HIV co-infection should start ART irrespective of CD4 count. Treatment supervision and adherence evaluation are very important.

Suggested timing of ART initiation in TB/HIV co-infection according to CD4 count

< 50 cells/μL^{*,**} : As soon as TB treatment is tolerated and wherever possible within 2 weeks

≥ 50 cells/μL: Can be deferred until between 8 and 12 weeks of TB treatment, especially when there are difficulties with drug-drug interactions, adherence and toxicities

Although a RCT showed that early ART (within 2 weeks) did not reduce mortality in TB meningitis, recommendations on ART initiations should be based on the CD4 count in HIV-positive persons with TB co-infection.

- * Be aware of IRIS reaction in persons starting ART at low CD4 count levels and with early initiation of ART. Corticosteroids should be considered for treatment of symptomatic IRIS, with dosages and duration tailored according to response. See online video lectures [HIV and IRIS-Part 1](#) and [HIV and IRIS-Part 2](#) from the EACS online course Clinical Management of HIV.
- ** Although the data suggest a cut-off of 50 cells/μL, because of the daily variability in CD4 count, a cut-off of 100 cells/μL may be more appropriate.

Recommended 1st line ARV combination with anti-TB medicines

TDF/FTC + RAL or TDF/FTC/EFV (see table for dose adjustment with rifamycins).

Alternatives

Where combinations are not recommended or to be used with caution or because of resistance/intolerance, specialist HIV treatment advice should be sought.

- TDF/FTC + PI/r, using rifabutin instead of rifampicin (see table for dose adjustment of rifabutin). Use with caution.
- TDF/FTC + DTG bid with rifampicin.

In countries where neither DTG nor rifabutin are available, following combinations could also represent a short-term alternative until anti-TB treatment has been completed.

- Rifampicin plus fixed-dose combination of ABC/3TC/ZDV bid + TDF qd (if HIV-VL < 100,000 copies/mL).
- Rifampicin plus double dose LPV/r or with RTV super boosted (400 mg bid) + LPV.
- For other regimens based on 2 NRTIs plus NVP, RPV, ETV or MVC, consultation with an HIV specialist is recommended.

Important drug-drug interactions between ART and rifampicin / rifabutin

ARV drug class	Specific ARVs	Drug-drug interactions and recommended adjustment of dose of either or both drugs
NRTIs⁽ⁱ⁾		rifampicin: standard dose of all drugs rifabutin: standard dose of all drugs
PI/r and PI/c		rifampicin: not recommended
PI/r	Monitor liver enzymes and, whenever possible, perform TDM for PI	rifabutin: dose as 150 mg qd ⁽ⁱⁱ⁾ . PI/r at standard dose
PI/c		rifabutin: not recommended. If needed recommended dose of rifabutin: 150 mg qd ⁽ⁱⁱ⁾
NNRTIs	EFV	rifampicin: No dose change required. EFV: standard dose ARV TDM recommended after 2 weeks rifabutin: 450 mg qd. EFV: standard dose
	NVP	neither rifampicin nor rifabutin recommended
	RPV	rifampicin: not recommended rifabutin: standard dose. RPV dose should be increased (use with caution)
	ETV	rifampicin: not recommended rifabutin: standard dose of both drugs (few data – use with caution)
INSTI	EVG/c	rifampicin: not recommended rifabutin: 150 mg qd. EVG: standard dose. Use with caution.
	RAL	rifampicin: standard dose. RAL 400 or 800 mg bid and perform TDM for RAL. No data with RAL 1200 mg: do not use rifabutin: standard dose of both drugs
	DTG	rifampicin: standard dose. DTG 50 mg bid (use only in absence of INSTI resistance) rifabutin: standard dose of both drugs
	BIC	rifampicin: not recommended rifabutin: no data available, not recommended
Other ART	MVC	rifampicin: MVC 600 mg bid rifabutin: standard dose of MVC (300 mg bid in absence of a PI, 150 mg bid in presence of a PI)

- i The drug-drug interaction between TAF and rifampicin has not been evaluated in a clinical trial, therefore no clinical outcomes are available yet (only PK data available).
- ii Initial pharmacokinetic studies in healthy volunteers showed that concentrations of rifabutin and its active metabolite were significantly increased when combined with PI/r. Thus, a reduction of rifabutin dosage to 150 mg x3/week was recommended to reduce the risk of rifabutin-related toxicity. However, more recent pharmacokinetic data derived from HIV/TB co-infected persons have shown that the co-administration of LPV/r or ATV/r with rifabutin (150 mg x3/week) resulted in rifabutin concentrations that were lower than those observed with rifabutin 300 mg x1/day without PI/r suggesting that rifabutin dosage may be inadequate. Cases of relapses with acquired rifamycin-resistant TB have been described in co-infected persons treated with rifabutin 150 mg x3/week and LPV/r or ATV/r. The US guidelines for HIV treatment recommend the administration of rifabutin at 150 mg qd with PI/r. Due to the limited safety data with this dose and combination, persons receiving rifabutin 150 mg qd with PI/r should be closely monitored for rifabutin related toxicities (i.e. uveitis or neutropenia).
- iii Few data are available. Use with caution and always seek the advice of an HIV specialist. Some experts advise that, in presence of COBI a rifabutin dose of 150 mg x3/week may be used in order to reduce the risk of toxicity. If used at 150 mg qd, enhanced monitoring of rifabutin toxicity is needed.

Post-exposure Prophylaxis (PEP)

PEP recommended in case of:

Risk	Nature of exposure	Status of source person
Blood	Subcutaneous or intramuscular penetration with iv or im needle, or intravascular device	HIV-positive or recent serostatus unknown, but presence of HIV risk factors
	Percutaneous injury with sharp instrument (lancet), im or sc needle, suture needle Contact > 15 min of mucous membrane or non-intact skin	HIV-positive
Genital secretions	Anal or vaginal sex	Viraemic HIV-positive or serostatus unknown but presence of HIV risk factors. If source person is on ART, PEP should be started, HIV-VL should be repeated, and, if undetectable, PEP can be stopped
	Receptive oral sex with ejaculation	Viraemic HIV-positive
Intravenous drug use	Exchange of syringe, needle, preparation material or any other material	HIV-positive

- Rapid testing of the source person for HCV and HIV (if HIV-status unknown) recommended.
- If source person HIV-positive on ART, order resistance testing if HIV-VL detectable.
- Individualise PEP according to the source's treatment history and previous resistance tests.
- For sexual exposure, if HIV-positive source has documented undetectable HIV-VL, PEP is no longer recommended.
- PEP to be started ideally < 4 hours after the exposure, and no later than 48/72 hours.
- Duration of PEP: 4 weeks (unless discontinued due to lack of indication)
- PEP regimens: TDF/FTC (alternative: ZDV/3TC) + RAL bid, or + DRV/r qd or + LPV/r bid. TDF/FTC + DTG qd may be also considered as an alternative.
- Clinical experience with TAF in the PEP setting is lacking, hence its use should be avoided.
- Full sexual health screen in case of sexual exposure.
- Emergency contraception counselling for sexual exposure.
- Follow-up:
 - HIV serology + HBV and HCV, pregnancy test (women) within 48 hours of exposure
 - Re-evaluation of PEP indication by HIV expert within 48-72 hours
 - Assess tolerability of PEP regimen
 - Transaminases, HCV-PCR and HCV serology at month 1 if source person HCV-positive (observed or suspected)

Pre-exposure Prophylaxis (PrEP)

1. PrEP should be used in adults at high-risk of acquiring HIV infection when condoms are not used consistently. Before PrEP is initiated, HBV serology status should be documented.

- Recommended in HIV-negative men who have sex with men (MSM) and transgender individuals when condoms are not used consistently with casual partners or with HIV-positive partners who are not on treatment. A recent STI, use of post-exposure prophylaxis or chemsex may be markers of increased risk for HIV acquisition.
- May be considered in HIV-negative heterosexual women and men who are inconsistent in their use of condoms and have multiple sexual partners where some of whom are likely to have HIV infection and not being on treatment.

2. PrEP is a medical intervention that provides a high level of protection against HIV acquisition but does not protect against other STIs and should be used in combination with other preventive interventions. PrEP should be supervised by a doctor, experienced with sexual health and use of HIV medicines, possibly as part of a shared care arrangement.

The following procedures are recommended:

- Documented negative fourth generation HIV test prior to starting PrEP. During PrEP, this test should be repeated every 3 months, and PrEP should be stopped immediately in case of early clinical signs of HIV seroconversion or a positive HIV diagnostic test and the person referred for evaluation to an HIV unit.

- Before PrEP is initiated, HBV serology status should be documented. If HBsAg positive, see [Clinical Management and Treatment of HBV and HCV Co-infection in HIV-positive Persons](#).
- Counsel that PrEP does not prevent other types of STIs; screen for STI (including HCV) when starting PrEP and regularly during use of PrEP.
- Counsel that PrEP may impact renal and bone health, see pages 49 and 52-53. Check renal function before starting PrEP and check renal function and bone mineral density during PrEP according to guidelines on TDF use.
- Counsel that PrEP, like other prevention methods, only works when it is taken. Adherence counselling is recommended.
- Counsel that PrEP can be prescribed long-term but that each consecutive PrEP prescription should be for a period of maximum 3 months (90 tablets) to ensure appropriate monitoring.

See online video lectures [PrEP-Part 1](#) and [PrEP-Part 2](#) from the EACS online course Clinical Management of HIV.

3. PrEP regimen

- TDF/FTC 300*/200 mg 1 tablet qd. For MSM with high-risk sexual behaviour PrEP may be dosed 'on demand' (double dose of TDF/FTC 2-24 hours before each sexual intercourse, followed by two single doses of TDF/FTC, 24 and 48 hours after the first drug intake). If dosed 'on demand', the total dose per week should not exceed 7 tablets.
- Use of generic formulations of TDF/FTC, if and where available, may help to improve the cost-effectiveness of PrEP, which is essential for its use as public health approach.
- There are not currently clinical data on the use of 3TC or TAF for PrEP.

* In certain countries TDF is labelled as 245 mg rather than 300 mg to reflect the amount of the prodrug (tenofovir disoproxil) rather than the fumarate salt (tenofovir disoproxil fumarate).

Adverse Effects of ARVs and Drug Classes

Bold: Frequent effects
Red: Severe effects
Black: Neither Frequent nor Severe⁽ⁱ⁾

	Skin	Digestive	Liver	CV	Musculo-skeletal	Genito-urinary	Nervous	Body fat	Metabolic	Other
NRTIs										
ABC	Rash*	Nausea* Diarrhoea*		IHD						*Systemic hypersensitivity syndrome (HLA B*5701 dependent)
ZDV ⁽ⁱⁱⁱ⁾	Nail pigmentation	Nausea	Steatosis		Myopathy, Rhabdomyolysis			Lipoatrophy	Dyslipidaemia, Hyperlactaemia	Anaemia
d4T ⁽ⁱⁱⁱ⁾		Pancreatitis	Steatosis				Peripheral neuropathy		Dyslipidaemia, Hyperlactaemia	
ddI ⁽ⁱⁱⁱ⁾			Steatosis, Liver fibrosis	IHD					Hyperlactaemia	
3TC										
FTC										
TDF ⁽ⁱⁱⁱ⁾			Hepatitis		↓ BMD, Osteomalacia ↑ Fractures risk	↓ eGFR, Fanconi syndrome				
TAF ⁽ⁱⁱⁱ⁾										
NNRTIs										
EFV	Rash		Hepatitis				Depression, Sleep disturbances, Headache, Suicidal ideation		Dyslipidaemia, Gynaecomastia	↓ plasma 25(OH) vitamin D
ETV	Rash									
NVP	Rash*		Hepatitis*							*Systemic hypersensitivity (CD4 count and gender dependent)
RPV	Rash		Hepatitis			↓ eGFR ^(iv)	Depression, Sleep disturbances, Headache			
PIs										
ATV ^(v)		Nausea and Diarrhoea ^(vii)	Hyperbilirubinaemia, Jaundice, Cholelithiasis			↓ eGFR, Nephrolithiasis			Dyslipidaemia	
DRV ^(v)	Rash			IHD		Nephrolithiasis			Dyslipidaemia	
FPV ^(vi)	Rash			IHD					Dyslipidaemia	
IDV ^(vi)	Dry skin, Nail dystrophy		Jaundice	IHD		Nephrolithiasis		↑ Abdominal fat	Dyslipidaemia, Diabetes mellitus	
LPV				IHD		↓ eGFR			Dyslipidaemia	
SQV ^(vi)									Dyslipidaemia	
TPV ^(vi)			Hepatitis				Intracranial haemorrhage		Dyslipidaemia	
Boosting										
RTV						↓ eGFR ^(iv)				
COBI						↓ eGFR ^(iv)				

	Skin	Digestive	Liver	CV	Musculo-skeletal	Genito-urinary	Nervous	Body fat	Metabolic	Other
FI										
ENF	Injection nodules									Hypersensitivity
INSTI										
RAL		Nausea			Myopathy, Rhabdomyolysis		Sleep disturbances, Headache			Systemic hypersensitivity syndrome ^(viii)
DTG	Rash	Nausea				↓ eGFR ^(iv)	Sleep disturbances, Headache			Systemic hypersensitivity syndrome (< 1%)
EVG/c		Nausea, Diarrhoea				↓ eGFR ^(iv)	Sleep disturbances, Headache			
CCR5 inhibitor										
MVC			Hepatitis							

- i **"Frequent effects" (events expected in at least 10% of treated HIV-positive persons), in bold.**
"Severe effects" (events that can put a person's life at risk and represent a medical emergency), in red.
- ii "Neither frequent nor severe effects", in black.
- iii Still available, but generally not recommended due to toxicity.
- iv TDF has been the classical prodrug of tenofovir. TAF has lower tenofovir-related kidney and bone adverse effects, but long-term experience is lacking, see pages 52-53 and page 49.
- v Due to inhibition of renal tubular creatinine secretion without affecting glomerular filtration itself.
- v ATV can be used unboosted, or boosted with low-dose RTV or COBI. ATV-related adverse effects are more common with boosting. DRV can be used boosted with low-dose RTV or COBI. Both low-dose RTV and COBI as boosters may cause similar minor digestive problems.
- vi Still available but seldom used. Requires RTV-boosting.
- vii Frequency and severity differs between individual ARVs.
- viii DRESS syndrome reported, but currently in only 6 cases.
- * Refers to effects seen in relation to hypersensitivity reactions.

Note: the adverse effects included in the table above are not exhaustive, but represent the most important effects with a likely causal relation. Nausea, diarrhoea and rash are frequently observed in persons on ART, and these symptoms are indicated in the table for drugs where clinical experience suggests a possible causal link.

See online video lecture [Adverse Effects and Monitoring of ART](#) from the EACS online course Clinical Management of HIV.

Drug-drug Interactions between ARVs and Non-ARVs⁽ⁱ⁾

Non-ARV drugs	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
Cardiovascular drugs	atorvastatin	↑822%	↑	↑290%	↑	↑490%	↓43%	↓37%	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔
	fluvastatin	↑	↑	↑	↔	↔	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔
	pravastatin	↑	↑	↑	↑81%	↔	↓44%	↓	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔
	rosuvastatin	↑242%	↑213%	↑93%	↑48%	↑107%	↔	↔	↔	↔	↔	↔	↑38%	↔	↔	↔	↔	↔	↔
	simvastatin	↑	↑	↑	↑	↑	↓68%	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	amlodipine	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	diltiazem	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↓69%	↓E	E	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	metoprolol	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	verapamil	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↓	↓E	E	E	E	↔	↑	↔	↔	↔	↔	E	E
CNS drugs	warfarin	↑	↑ or ↓	↑	↓	↓	↑ or ↓	↑	↑ or ↓	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	diazepam	↑	↑	↑	↑	↑	↓	↑	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	midazolam (oral)	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	triazolam	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	citalopram	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↓	↓	↔ ^{iv}	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	mirtazapine	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	paroxetine	↑↓?	↑↓?	↑↓?	↓39%	↑↓?	↔	↔	↔	↔	↔	↔	↑↓?	↔	↔	↔	↔	↔	↔
	sertraline	↑	↓	↑	↓49%	↓	↓39%	↓	↔	↔	↔	↔	↓7%	↔	↔	↔	↔	↔	↔
	bupropion	↔	↓	↔	↓	↓57%	↓55%	↔	↓	↔	↔	↔	↑?	↔	↔	↔	↔	↔	↔
Anti-infectives	pimozide	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↑	↓	↔ ^{iv}	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	carbamazepine	↑D	↑D	↑D	↑	↑D	↓27%D36%	D	↓D	D	D	D	D	D ^{xii}	↑	↔	↔	D	↔
	lamotrigine	↔	↓32% ⁱⁱ	↔	↓	↓50%	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	phenytoin	D	↓D	D	↓D	↓D	↓D	↓D	D	D	D	D	D	D ^{xii}	D	↔	↔	D	↔
	clarithromycin	↑E ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↓	↓E	E	E	E	↔	↑E	↔	↔	↔	↔	E	E
	fluconazole	↑?	↔	↑?	↔	↔	↔	E86%	E100%	E	↔	↔	↑?	↔	↔	↔	↔	E?	↔
	itraconazole	↑E	↑E	↑E	↑E	↑E	↓	↓E	↓61%	E	E	E	↔	↑E	↔	↔	↔	E	E
	rifabutin	↑D	↑	↑D	↑E50%	↑	↓38%	D37%	↑17%	D	*	D	↔	↑D	↔	↔	↔	D ^{xi}	↔
	rifampicin	D	D72%	D	D	D	D26%	D	D58%	D80%	D	D	D54% ^x	D	D40% ^{xii}	D	↔	D ^{xi}	↔
Miscellaneous	voriconazole	↑E	↓	↑E	↓	↓	↓E	↑E	↓E	E	E	E	↔	↑E	↔	↔	↔	↔	↔
	antacids	D	D	↔	↔	↔	↔	↔	↔	D	↔	D	D	D ^{xiii}	↔	↔	↔	↔	↔
	PPIs	D	D	↔	↔	↔	↔	↔	↔	D	↔	↔	↔	E	↔	↔	↔	↔	↔
	H2 blockers	D	D	↔	↔	↔	↔	↔	↔	D	↔	↔	↔	E	↔	↔	↔	↔	↔
	alfuzosin	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	beclometasone inhal.	↑ ^v	↑ ^v	↑?	↓11%	↑ ^v	↔	↔	↔	↔	↔	↔	↑ ^v	↔	↔	↔	↔	↔	↔
	buprenorphine	↑	↑67%	↑	↑ ^{vi}	↔	↓50%	↓25%	↔	↔	↔	↔	↔	↑35%	↔	↔	↔	↔	↔
	budesonide inhal.	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	ergot derivatives	↑	↑	↑	↑	↑	↑	↓	E	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	ethinylestradiol	↔	↓19% ^{vii}	↑30%	↓44%	↓42%	↔ ^{viii}	↑22%	↓20%	↑14%	↔	↔	↑3%	↓25%	↔	↔	↔	↔	↔
	fluticasone inhal.	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	methadone	↑? ⁱⁱⁱ	↓ ^{ii,iii}	↑?	↓16%	↓53% ⁱⁱⁱ	↓52%	↑6%	↓≈50%	↓16%	↔	↔	↑7%	↔	↓	↔	↔	↔	↔
	salmeterol inhal.	↑ ⁱⁱⁱ	↑ ⁱⁱⁱ	↑	↑	↑ ⁱⁱⁱ	↓	↓	↔ ^{iv}	↔	↔	↔	↑ ⁱⁱⁱ	↔	↔	↔	↔	↔	↔
	sildenafil (erect. dys.)	↑	↑	↑	↑	↑	↓	↓37%	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	St John's wort	D	D	D	D	D	D	D	D	D	D	D	D	D	↔	↔	↔	D	↔
	varenicline	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Comments

ⁱ This table summarises the drug-drug interactions between HIV therapy and some commonly prescribed co-medicines as well as the drug-drug interactions of particular clinical relevance. This table is not exhaustive. For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, see <http://www.hiv-druginteractions.org> (University of Liverpool).

Legend

↑ potential elevated exposure of non-ARV drug
 ↓ potential decreased exposure of non-ARV drug
 ↔ no significant effect
 E potential elevated exposure of ARV
 D potential decreased exposure of ARV

Numbers refer to decreased/increased AUC of non-ARV/ARV drugs as observed in drug interactions studies.

ATV/c ATV co-formulated with COBI (300/150 mg qd);

DRV/c DRV co-formulated with COBI (800/150 mg qd)

ⁱⁱ no PK changes with unboosted PI

ⁱⁱⁱ ECG monitoring is recommended

^{iv} RPV manufacturer recommends caution when co-administering with another drug susceptible to prolong QT interval

^v increase in concentration of active metabolite observed with RTV 100 mg bid alone but without significant effect on adrenal function. Caution is still warranted, use the lowest possible corticosteroid dose and monitor for corticosteroid side effects.

^{vi} concentration of parent drug unchanged but concentration of metabolite increased

^{vii} increase in ethinylestradiol with unboosted ATV

^{viii} no effect on ethinylestradiol but ↓ progestin

^{ix} potential haematological toxicity

^x administer DTG at a dose of 50 mg bid in treatment-naïve or INSTI-naïve HIV-positive persons. Alternative to rifampicin should be used where possible for INSTI-experienced HIV-positive persons with certain INSTI-associated resistance substitutions or clinically suspected INSTI resistance

^{xi} interaction can be overcome by administering TAF 25 mg bid;

^{xii} co-administration of RAL 1200 mg qd is not recommended with strong inducers. If co-administration is unavoidable, RAL should be used 400 mg bid with monitoring of response,

^{xiii} Al, Mg containing antacids: not recommended with RAL 400 mg bid or RAL 1200 mg qd. If co-administration with antacid is unavoidable, calcium carbonate antacids can be used but only with RAL 400 mg bid

* no dose adjustment for MVC in absence of PI. With PI (except TPV/r; FPV/r), give MVC 150 mg bid

Note: interactions with ZDV: clarithromycin, rifampicin (decrease in ZDV exposure), fluconazole, rifampicin (increase in ZDV exposure), carbamazepine (increase in carbamazepine exposure), phenytoin (decrease in phenytoin exposure)

Colour legend

no clinically significant interaction expected

these drugs should not be co-administered

potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration

potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).



Drug-drug Interactions between Antidepressants and ARVs

Antidepressants		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL
SSRI	citalopram	↑ ^a	↑ ^a	↑	↑	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑	↔
	escitalopram	↑ ^a	↑ ^a	↑	↑	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑	↔
	fluvoxamine	↑	↑	↑	↑	↑	↔	↔	E	↔	↔	↔	↔	↑	↔
	fluoxetine	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	paroxetine	↑↓?	↑↓?	↑↓?	↓39%	↑↓?	↔	↔	↔	↔	↔	↔	↔	↑↓?	↔
	sertraline	↑	↓	↑	↓49%	↓	↓39%	↓	↓	↔	↔	↔	↔	↓7%	↔
SNRI	duloxetine	↑	↑↓	↑	↑↓	↑↓	↔	↔	↔	↔	↔	↔	↔	↑	↔
	venlafaxine	↑	↑	↑	↑	↑	↓	↓	↓	↔	D	↔	↔	↑	↔
TCA	amitriptyline	↑ ^a	↑ ^a	↑	↑	↑ ^a	↔	↔	↔	↔ ^b	↔	↔	↔	↑	↔
	clomipramine	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑ ^a	↔
	desipramine	↑ ^a	↑ ^a	↑	↑	↑5% ^a	↔	↔	↔	↔ ^b	↔	↔	↔	↑	↔
	doxepin	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	imipramine	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑ ^a	↔
	nortriptyline	↑ ^a	↑ ^a	↑	↑	↑ ^a	↔	↔	↔	↔ ^b	↔	↔	↔	↑	↔
TeCA	trimipramine	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	maprotiline	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	mianserine	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔
Oth-ers	mirtazapine	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔
	bupropion	↔	↓	↔	↓	↓57%	↓55%	↔	↓	↔	↔	↔	↔	↑?	↔
	lamotrigine	↔	↓32%	↔	↓	↓50%	↓	↔	↔	↔	↔	↔	↔	↔	↔
	nefazodone	↑	↑	↑	↑	↑	↓E	↓E	↓E	E	E	E	↔	↑	↔
	St John's wort	D	D	D	D	D	D	D	D	D	D	D	D ^c	D	D
	trazodone	↑ ^a	↑ ^a	↑	↑	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑	↔

Legend

- ↑ potential elevated exposure of the antidepressant
- ↓ potential decreased exposure of the antidepressant
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a ECG monitoring is recommended
- ^b caution as both drugs can induce QT interval prolongation
- ^c the US Prescribing Information recommends that co-administration should be avoided as there are insufficient data to make dosing recommendations

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Numbers refer to decreased AUC of the antidepressant as observed in drug-drug interactions studies.

Note: no clinically relevant interactions expected between ZDV (or any other NRTI) and antidepressants

- SSRI** selective serotonin reuptake inhibitors
- SNRI** serotonin and norepinephrine reuptake inhibitors
- TCA** tricyclic antidepressants
- TeCA** tetracyclic antidepressants

Drug-drug Interactions between Antihypertensives and ARVs

Antihypertensives		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
ACE inhibitors	captopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	cilazapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	enalapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	lisinopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	perindopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	quinapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	ramipril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	trandolapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Angiotensin antagonists	candesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	eprosartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	irbesartan	↔	↓	↔	↓	↓	↑	↑	↔	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	losartan	↔	↓ ^a	↔	↓ ^a	↓ ^a	↑ ^b	↑ ^b	↔	↔	↔	↔	↔	↓ ^a	↔	↔	↔	↔	↔	↔
	olmesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	telmisartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	valsartan	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
β blockers	atenolol	↔ ^d	↔ ^d	↔	↔	↔ ^d	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bisoprolol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	carvedilol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↑	↑	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	metoprolol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	propranolol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	atenolol	↔ ^d	↔ ^d	↔	↔	↔ ^d	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Calcium channel blockers	amlodipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	diltiazem	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓69%	↓E	↓	E	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	felodipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lacidipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lercanidipine	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nicardipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓E	↓	E	E	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nifedipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nisoldipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	verapamil	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓E	↓	E	E	E	↔	↑	↔	↔	↔	↔	E	E
	verapamil	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓E	↓	E	E	E	↔	↑	↔	↔	↔	↔	E	E
Diuretics	amiloride	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bendroflumethiazide	?	?	?	?	?	?	?	?	↔	↔	↔	↔	?	↔	↔	↔	↔	↔	↔
	chlortalidone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	furosemide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E
	indapamide	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	hydrochlorothiazide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	torasemide	↔	↓	↔	↓	↓	↑	↑	↔	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
Others	doxazosin	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sacubitril	↑	↑	↑	↑	↑	↔	↔	↔	↔	E	↔	↔	↔	↔	↔	↔	↔	↔	↑
	spironolactone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of the antihypertensive
- ↓ potential decreased exposure of the antihypertensive
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a [parent drug] decreased but [active metabolite] increased
- ^b [parent drug] increased but [active metabolite] decreased
- ^c ECG monitoring recommended
- ^d risk of PR interval prolongation
- ^e use with caution as both LPV and calcium channel blockers prolong the PR interval. Clinical monitoring is recommended.

Numbers refer to decreased AUC of the antihypertensive as observed in drug-drug interactions studies.

Note: no clinically significant interactions expected between ZDV and antihypertensives

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required
- there are no clear data, actual or theoretical, to indicate whether an interaction will occur

Note: although some drug interactions are predicted to potentially require a dosage adjustment based on the drug's metabolic pathway, clinical experience with a particular antihypertensive and ARV drug may indicate that dosage adjustments are not an *a priori* requirement.

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Analgesics and ARVs

Analgesics	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
Non-opioid analgesics	aspirin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	g
	celecoxib	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	g
	diclofenac	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	Eg
	ibuprofen	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	Eg
	mefenamic acid	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	Eg
	naproxen	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	Eg
	nimesulide	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	g
	paracetamol	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	piroxicam	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	g
Opioid analgesics	alfentanil	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	buprenorphine	↑	↑67%	↑	↑ ^b	↔	↓50%	↓25%	↔	↔	↔	↔	↑35%	↔	↔	↔	↔	↔	↔
	codeine	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↓ ^d	↓ ^d	↓ ^d	↔	↔	↔	↑ ^d	↔	↔	↔	↔	↔	↔
	dihydrocodeine	↑	↓↑	↑	↓↑	↓↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	fentanyl	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	methadone	↑ ^c	↓ ^c	↑?	↓16%	↓53% ^c	↓52%	↑6%	↓≈50%	↓16%	↔	↔	↑7%	↔	↓	↔	↔	↔	↔
	morphine	↔ ^h	↓ ^h	↔ ^h	↓ ^h	↓ ^h	↑	↔ ^h	↔	↔	↔	↔	↔ ^h	↔	↔	↔	↔	↔	↔
	oxycodone	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	pethidine	↑	↓ ^e	↑	↓ ^e	↓ ^e	↓ ^e	↓ ^e	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sufentanil	↑	↑	↑	↑	↑	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	tramadol	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↓ ^f	↔	↔	↔	↔	↔	↑ ^d	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of the analgesic
- ↓ potential decreased exposure of the analgesic
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- a clinical significance unknown. Use the lowest recommended dose particularly in individuals with risk factors for CVD, those individuals at risk of developing gastrointestinal complications, persons with hepatic or renal impairment, and in elderly persons
- b [parent drug] unchanged but [metabolite] increased
- c both drugs can potentially prolong the QT interval, ECG monitoring recommended
- d potential decrease of the analgesic effect due to the reduced conversion to the active metabolite
- e [parent drug] decreased and increased [neurotoxic metabolite]
- f [parent drug] decreased but no change in [more active metabolite]
- g potential risk of nephrotoxicity which is increased if NSAID is used for a long duration, if the person has a pre-existing renal dysfunction, a low body weight or receives other drugs that may increase TDF exposure. Concurrent use of NSAIDs with TDF warrants monitoring of renal function
- h inhibition of P-gp by RTV and COBI could potentiate the effect of opiate in the CNS

Numbers refer to increased or decreased AUC of the analgesic as observed in drug-drug interactions studies

Note: interactions with ZDV: ibuprofen, naproxen (potential additive hematological toxicity); methadone (moderate increase in ZDV exposure, monitor for toxicity)

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Anticoagulants/Antiplatelet Agents and ARVs

		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
Anticoagulants	acenocoumarol	↔	↓	↔	↓	↓	↓	↑	↓	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	apixaban	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	dabigatran	↑	↑	↑	↑	↑?	↔	↑	↔	↑?	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	dalteparin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	edoxaban	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	enoxaparin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	fondaparinux	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	heparin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	phenprocoumon	↑	↑or↓ ^a	↑	↑or↓	↑or↓	↓	↑or↓	↓	↔	↔	↔	↔	↑or↓	↔	↔	↔	↔	↔	↔
	rivaroxaban	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
Antiplatelet agents	warfarin	↑	↑or↓ ^a	↑	↓	↓	↑or↓	↑	↑or↓	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	aspirin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	clopidogrel	↓ ^b	↓ ^b	↓ ^b	↓ ^b	↓ ^b	↓ ^b	↓ ^b	↑ ^c	↔	↔	↔	↔	↓ ^b	↔	↔	↔	↔	↔	↔
	dipyridamole	↑	↓ ^d	↔	↓	↓	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	prasugrel	↓ ^e	↓ ^e	↓ ^e	↓ ^e	↓ ^e	↔	↔	↔	↔	↔	↔	↔	↓ ^e	↔	↔	↔	↔	↔	↔
	ticagrelor	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of the anticoagulant/antiplatelet agent
- ↓ potential decreased exposure of the anticoagulant/antiplatelet agent
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a unboosted ATV predicted to increase the anticoagulant, monitor INR and adjust the anticoagulant dosage accordingly
- ^b decreased conversion to active metabolite leading to non-responsiveness to clopidogrel. An alternative to clopidogrel should be considered
- ^c increase in amount of active metabolite via induction of CYP3A4 and CYP2B6
- ^d unboosted ATV predicted to increase dipyridamole exposure due to UGT1A1 inhibition
- ^e reduced active metabolite, but without a significant reduction in prasugrel activity

Note: no clinically significant interactions expected between ZDV and anticoagulants or platelet agents

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Bronchodilators (for COPD) and ARVs

Bronchodilators		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
LAMA	acclidinium bromide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	glycopyrronium bromide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	tiotropium bromide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	umeclidinium bromide	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
SAMA	ipratropium	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
LABA	formoterol	↔ ^a	↔ ^a	↔	↔	↔ ^a	↔	↔	↔	↔ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	indacaterol	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↓	↓	↓	↔	↔	↔	↔	↑ ^d	↔	↔	↔	↔	↔	↔
	olodaterol	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	salmeterol	↑ ^b	↑ ^b	↑ ^b	↑ ^b	↑ ^b	↓	↓	↓	↔ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	vilanterol	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
SABA	salbutamol (albuterol)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
MX	aminophylline	↔	↓	↔	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	theophylline	↔	↓	↔	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
PDE4	roflumilast	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
ICS	beclometasone	↑ ^c	↑ ^c	↑ ^c	↓11%	↑ ^c	↔	↔	↔	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	budesonide	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	fluticasone	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of the bronchodilator
- ↓ potential decreased exposure of the bronchodilator
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a caution as both drugs can induce QT interval prolongation
- ^b ECG monitoring is recommended
- ^c increase in concentration of active metabolite observed with RTV 100 mg bid alone but without significant effect on adrenal function. Caution is still warranted, use the lowest possible corticosteroid dose and monitor for corticosteroid side effects
- ^d exposure can be increased up to 2-fold however this increase does not raise any concerns based on indacaterol's safety data

- ICS inhaled corticosteroids
- LABA long-acting β₂ agonists
- LAMA long-acting muscarinic antagonists
- MX methylxanthines
- PD4 phosphodiesterase 4 inhibitors
- SABA short-acting β₂ agonists
- SAMA short-acting muscarinic antagonists

Note: no clinically significant interactions expected between ZDV and bronchodilators

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Contraceptives and ARVs

		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
Es	ethinylestradiol (COC, TS, VR)	↔	↓19% ^a	↓30%	↓44% ^b	↓42% ^b	↔ ^c	↑22%	↓20%	↑14%	↔	↔	↑3%	↓25% ^d	↔	↔	↔	↔	↔	↔
	desogestrel (COC)	↑	↑ ^{e,a}	↑	↑ ^f	↑ ^f	↓ ^g	↓	↓	↔	↔	↔	↔	↑ ^{d,e}	↔	↔	↔	↔	↔	↔
	desogestrel (POP)	↑	↑ ^{e,a}	↑	↑	↑	↓ ^g	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	drosiprenone (COC)	↑	↑ ^{e,a}	↑ ^f	↑ ^f	↑ ^f	↓ ^g	↓	↓	↔	↔	↔	↔	↑ ^{d,e}	↔	↔	↔	↔	↔	↔
	etonogestrel (IP)	↑	↑	↑	↑	↑52%	↓63% ^g	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	etonogestrel (VR)	↑	↑≈80% ^h	↑	↑ ^h	↑ ^h	↓ ^g	↓	↓	↔	↔	↔	↔	↑ ^h	↔	↔	↔	↔	↔	↔
	gestodene (COC)	↑	↑ ^{e,a}	↑	↑ ^f	↑ ^f	↓ ^g	↓	↓	↔	↔	↔	↔	↑ ^{d,e}	↔	↔	↔	↔	↔	↔
	levonorgestrel (COC)	↑	↑ ^{e,a}	↑	↑ ^f	↑ ^f	↓ ^g	↓	↑	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	levonorgestrel (IP)	↑	↑	↑	↑	↑	↓47% ^g	↓	↑14%	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	levonorgestrel (POP)	↑	↑	↑	↑	↑	↓ ^g	↓	↑	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	levonorgestrel (IUD)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	medroxyprogesterone (POI)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	norelgestromin (TS)	↑	↑ ^{e,a}	↑	↑ ^f	↑83% ^f	↓ ^g	↓	↓	↔	↔	↔	↔	↑ ^{d,e}	↔	↔	↔	↔	↔	↔
	norethisterone (COC)	↑	↑ ^{e,a,i}	↑	↓14% ^f	↓17% ^f	↓ ^g	↓5%	↓19%	↓11%	↔	↔	↔	↑ ^{d,e}	↔	↔	↔	↔	↔	↔
	norethisterone (POI)	↔	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	norethisterone (POP)	↑	↑50%	↑	↑50%	↑50%	↓ ^g	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	norgestimate (COC)	↑	↑85% ^{e,a}	↑	↑ ^f	↑ ^f	↓64% ^g	↓	↓	↔	↔	↔	↔	↑126% ^{d,e}	↑14%	↔	↔	↔	↔	↔
	norgestrel (COC)	↑	↑ ^{e,a}	↑	↑ ^f	↑ ^f	↓ ^g	↓	↑	↔	↔	↔	↔	↑ ^{d,e}	↔	↔	↔	↔	↔	↔
Other	levonorgestrel (EC)	↑ ^j	↑ ^j	↑ ^j	↑ ^j	↑ ^j	↓58% ^k	↔	↔	↔	↔	↔	↔	↑ ^j	↔	↔	↔	↔	↔	↔
	mifepristone	↑ ^j	↑ ^j	↑ ^j	↑ ^j	↑ ^j	↓	↓	↓	E ^j	E ^j	↔	↔	↑ ^j	↔	↔	↔	↔	↔	↔
	ulipristal	↑ ^j	↑ ^j	↑ ^j	↑ ^j	↑ ^j	↓ ^l	↓ ^l	↓ ^l	↔	↔	↔	↔	↑ ^j	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential increased exposure of the hormone
- ↓ potential decreased exposure of the hormone
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a unboosted ATV increased ethinylestradiol AUC by 48%. Use no more than 30 µg of ethinylestradiol if co-administered with unboosted ATV and at least 35 µg of ethinylestradiol if co-administered with ATV/r
- ^b alternative or additional contraceptive measures are recommended or, if used for hormone replacement therapy, monitor for signs of oestrogen deficiency
- ^c depending on the contraceptive method, ethinylestradiol levels are either not significantly changed (COC) or significantly decreased (VR). Levels of coadministered progestin are markedly decreased. Use with EFV is not recommended as it may impair contraceptive efficacy
- ^d European SPC states a hormonal contraceptive should contain at least 30 µg ethinylestradiol
- ^e when used in a combination pill, the estrogen component is reduced to a small extent
- ^f when used in a combination pill, the estrogen component is significantly reduced, caution is recommended and additional contraceptive measures should be used
- ^g EFV is expected to decrease the progestin exposure and thereby impair the efficacy of the contraceptive method. A reliable method of barrier contraception must be used in addition to hormonal contraceptives
- ^h used in combination with ethinylestradiol (0.015 mg/d) which is predicted to be decreased. Since there is no possibility to adjust ethinylestradiol, caution is recommended and additional contraceptive measures should be used
- ⁱ unboosted ATV increased norethisterone AUC by 110%
- ^j unlikely to have clinical consequences as hormone is administered as single dose
- ^k use 3 mg as a single dose for emergency contraception. Of note, the doubling of the standard dose is outside the product license and there is limited evidence in relation to efficacy
- ^l not recommended, non hormonal emergency contraception (Cu-IUD) should be considered

Es = estrogens

Contraceptive options: **COC** - combined oral contraceptive, **EC** - emergency contraception, **IP** - implant, **IUD** - intrauterine device, **POI** - progestin only injectable, **POP** - progestin only pill, **TS** - transdermal patch, **VR** - vaginal ring

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity or unlikely to impair contraceptive efficacy. Additional action/monitoring or dosage adjustment is unlikely to be required

Note: no clinically significant interactions expected between ZDV and contraceptives

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Corticosteroids and ARVs

Corticosteroids		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
Inhaled, oral, topical and/or injected corticosteroids	beclometasone (inhalation)	↑ ^a	↑ ^a	↑ ^a	↓ ^b	↑ ^a	↔	↔	↔	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔
	betamethasone	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	D	D	D	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	budesonide (inhalation)	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	clobetasol (topical)	↑ ^{c,d}	↑ ^{c,d}	↑ ^{c,d}	↑ ^{c,d}	↑ ^{c,d}	↔	↔	↔	↔	↔	↔	↔	↑ ^{c,d}	↔	↔	↔	↔	↔	↔
	dexamethasone	↑ ^c D	↑ ^c D	↑ ^c D	↑ ^c D	↑ ^c D	↓D	↓D	↓D	D	D	D	↔	↑ ^c D	↔	↔	↔	↔	↔	↔
	flucinolone (topical)	↑ ^{c,d}	↑ ^{c,d}	↑ ^{c,d}	↑ ^{c,d}	↑ ^{c,d}	↔	↔	↔	↔	↔	↔	↔	↑ ^{c,d}	↔	↔	↔	↔	↔	↔
	fluticasone (inhalation)	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	hydrocortisone (oral)	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	hydrocortisone (topical)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	methylprednisolone	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	mometasone (inhalation)	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	prednisolone (oral)	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓ 40%	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	prednisone	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓ 40%	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	triamcinolone	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↑ ^c	↓	↓	↓	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential increased exposure of the corticosteroid
- ↓ potential decreased exposure of the corticosteroid
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- a co-administration of RTV (100 mg bid) increased the concentrations of the active metabolite (beclometasone-17-monopropionate) but no significant effect on adrenal function was seen. Caution is still warranted, use the lowest possible corticosteroid dose and monitor for corticosteroid side effects
- b DRV/r decreased the exposure of active metabolite (beclometasone-17-monopropionate), no significant effect on adrenal function was seen
- c risk of having elevated corticosteroid levels, Cushing's syndrome and adrenal suppression. This risk is present for oral, injected but also for topical, inhaled or eye drops corticosteroid
- d the extent of percutaneous absorption is determined by many factors such as degree of inflammation and alteration of the skin, duration, frequency and surface of application, use of occlusive dressings

Note: no clinically significant interactions expected between ZDV and corticosteroids

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential interaction which may require a dosage adjustment or close monitoring

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Antimalarial Drugs and ARVs

Antimalarial drugs	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
First line and second line drugs	amodiaquine	↔	↑	↔	↑	↑ ^c	↓?	↓29% ^c	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	artemisinin	↑	↑	↑	↑	↓≈50%	↓D	↓D	D	D	D	↔	↑	↔	↔	↔	↔	↔	↔
	atovaquone	↔	↓46% ^a	↔	↓ ^a	↓74% ^a	↓75% ^a	↓E55% ^a	↓ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	chloroquine	↔ ^b	↔ ^b	↔	↔	↔ ^b	↔	↔	↔	↔ ^e	↔	↔	↔	↔	↔	↔	↔	↔	↔
	clindamycin	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	doxycycline	↔	↔	↔	↔	↓?	↓?	↓?	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	lumefantrine	↑ ^b	↑ ^b	↑	↑	↑ ^b	↓≈40%	↓	↓D46%	↔ ^e	↔	↔	↔	↑	↔	↔	↔	↔	↔
	mefloquine	↑ ^b	↑ ^b	↑	↑	↑ ^b	↓	↓	↓	↔ ^e	↔	↔	↔	↑	↔	↔	↔	↔	↔
	primaquine	↔	↔	↔	↔	↔	↔ ^d	↔ ^d	↔ ^d	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	proguanil	↔	↓41% ^a	↔	↓ ^a	↓38% ^a	↓44% ^a	↓E55% ^a	↓ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	pyrimethamine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E	E	↔	↔
	quinine	↑ ^b	↑ ^b	↑	↑	↑ ^b	↓	↓	↓	↔ ^e	E	↔	↔	↑	↔	↔	↔	↔	↔
	sulfadoxine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E	E	↔	↔

Legend

- ↑ potential increased exposure of the antimalarial drug
- ↓ potential decreased exposure of the antimalarial drug
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a take with high fat meal, consider dose increase
- ^b ECG monitoring is recommended
- ^c liver toxicity
- ^d increase of haemotoxic metabolites
- ^e both drugs can induce QT interval prolongation (only at supratherapeutic dose for RPV)

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Note: interactions with ZDV: amodiaquine, atovaquone, primaquine, pyrimethamine, sulfadoxine (potential additive hematological toxicity)

Drug-drug Interactions between Pulmonary Antihypertensives and ARVs

Pulmonary antihypertensives	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
ERA	ambrisentan	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bosentan	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓	↓	↓ ^b	D	D	D	D	↑ ^a	↔	↔	↔	↔	↔	↔
	macitentan	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
PDE5	sildenafil	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	tadalafil	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
sGC	riociguat	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
PA	epoprostenol	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	iloprost	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	treprostinil	↔	↑	↔	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
IPr	selexipag	↔ ^c	↔ ^c	↔ ^c	↔ ^c	↔ ^c	↔	↔	↔	↔	↔	↔	↔ ^c	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential increased exposure of the pulmonary antihypertensive
- ↓ potential decreased exposure of the pulmonary antihypertensive
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a when starting bosentan in individuals already on PI/r, PI/c or EVG/c use a bosentan dose of 62.5 mg qd or every other day. Discontinue bosentan at least 36 h prior to starting PI/r, PI/c or EVG/c and restart after at least 10 days at 62.5 mg qd or every other day
- ^b potential additive liver toxicity
- ^c exposure of parent drug increased but exposure of active metabolite unchanged

- ERA** endothelin receptor antagonists
- IPr** IP receptor agonists
- PA** prostacyclin analogues
- PDE5** phosphodiesterase type 5 inhibitors
- sGC** soluble guanylate cyclase stimulators

Note: no clinically significant interactions expected between ZDV and pulmonary antihypertensives

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Immunosuppressants (for SOT) and ARVs

Immunosuppressants	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
CS	prednisone	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
AM	azathioprine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	mycophenolate	↔	↓	↔	↓	↓	↔	↓D13%	↔	↔	↔	↔	↔	↔	↓?	↔	↔	↔	↑E ^b
CNI	cyclosporine	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓ ^a	↓ ^a	↓ ^a	E	E	E	↔	↑ ^a	↔	↔	↔	↔	E	E ^b
	tacrolimus*	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓ ^a	↓ ^a	↓ ^a	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔ ^b
mTOR	everolimus	↑	↑	↑	↑	↓ ^a	↓ ^a	↓ ^a	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sirolimus	↑	↑	↑	↑	↓ ^a	↓ ^a	↓ ^a	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔ ^b
Other	anti-thymocyte globulin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	basiliximab	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	belatacept	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Legend

↑ potential increased exposure of the immunosuppressant
 ↓ potential decreased exposure of the immunosuppressant
 ↔ no significant effect
 D potential decreased exposure of ARV drug
 E potential elevated exposure of ARV drug
 ATV/c ATV co-formulated with COBI (300/150 mg qd);
 DRV/c DRV co-formulated with COBI (800/150 mg qd)
 * available as prolonged release formulation

Numbers refer to decreased/increased AUC of the immunosuppressant as observed in drug-drug interaction studies

^a TDM of immunosuppressant is recommended
^b monitor renal function

AM antimetabolite
CNI calcineurin inhibitors
CS corticosteroids
mTOR mTOR inhibitors

Note: interactions with ZDV: azathioprine (potential risk of additive hematotoxicity); mycophenolate (potential decrease in mycophenolate level, monitor plasma level)

Colour legend

↔ no clinically significant interaction expected
 ↓ these drugs should not be co-administered
 ↓ potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
 ↓ potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Dose Adjustment of ARVs for Impaired Hepatic Function

NRTIs	
ABC	Child-Pugh Class A: 200 mg bid (use oral solution) Child-Pugh Class B or C: contraindicated
ddl	Contraindicated If used no dosage adjustment
d4T	Contraindicated If used no dosage adjustment
FTC	No dosage adjustment
3TC	No dosage adjustment
TAF	No dosage adjustment
TAF/FTC	No dosage adjustment
TDF	No dosage adjustment
TDF/FTC	No dosage adjustment
ZDV	Reduce dose by 50% or double the interval between doses if Child-Pugh Class C
NNRTIs	
EFV	No dosage adjustment; use with caution in persons with hepatic impairment
TDF/FTC/EFV	
ETV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
NVP	Child-Pugh Class B or C: contraindicated
RPV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TAF/FTC/RPV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TDF/FTC/RPV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data

PIs	
ATV	Child-Pugh Class A: no dose adjustment Child-Pugh Class B: 300 mg qd (unboosted) Child-Pugh Class C: not recommended
ATV/c	Child-Pugh Class A: no dosage adjustment Child-Pugh Class B or C: not recommended
COBI	Refer to recommendations for the primary PI
DRV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: not recommended
DRV/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: not recommended
TAF/FTC/DRV/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: not recommended
FPV	PI-naïve persons: Child-Pugh Class A or B: 700 mg bid Child-Pugh Class C: 350 mg bid PI-experienced persons: Child-Pugh Class A: 700 mg bid + RTV 100 mg qd Child-Pugh Class B: 450 mg bid + RTV 100 mg qd Child-Pugh Class C: 300 mg bid + RTV 100 mg qd
IDV	Child-Pugh Class A or B: 600 mg q8h Child-Pugh Class C: no data
LPV/r	No dosage recommendation; use with caution in persons with hepatic impairment
RTV	Refer to recommendations for the primary PI
SQV	Child-Pugh Class A or B: use with caution Child-Pugh Class C: contraindicated
TPV	Child-Pugh Class A: use with caution Child-Pugh Class B or C: contraindicated
FI	
ENF	No dosage adjustment
CCR5 Inhibitor	
MVC	No dosage recommendations. Concentrations will likely be increased in persons with hepatic impairment
INSTI	
RAL	No dosage adjustment
EVG	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
DTG	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TAF/FTC/EVG/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TDF/FTC/EVG/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
ABC/3TC/DTG	Use separate compounds and refer to those adjustments
TAF/FTC/BIC	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data

Note: Hepatic dysfunction is a good indication for TDM as clinical experience with these dose adjustments is very limited.

Dose Adjustment of ARVs for Impaired Renal Function

eGFR ⁽ⁱ⁾ (mL/min)						Haemodialysis
		≥ 50	30-49	10-29	< 10	
NRTIs						
ABC		300 mg q12h	No dose adjustment required			
ddl ⁽ⁱⁱ⁾	≥ 60 kg	400 mg q24h	200 mg q24h	150 mg q24h	100 mg q24h	100 mg q24h ^(iv)
	< 60 kg	250 mg q24h	125 mg q24h	100 mg q24h	75 mg q24h	75 mg q24h ^(iv)
d4T	≥ 60 kg	40 mg q12h	20 mg q12h	20 mg q24h	20 mg q24h	20 mg q24h ^(iv)
	< 60 kg	30 mg q12h	15 mg q12h	15 mg q24h	15 mg q24h	15 mg q24h ^(iv)
FTC		200 mg q24h	200 mg q48h	200 mg q72h	200 mg q96h	200 mg q96h ^(iv)
3TC		300 mg q24h	150 mg q24h	100 mg q24h ⁽ⁱⁱⁱ⁾	50-25 mg q24h ⁽ⁱⁱⁱ⁾	50-25 mg q24h ^{(iii), (iv)}
TDF ^(v)		300 ^(viii) mg q24h	300 ^(viii) mg q48h	Not recommended (300 ^(viii) mg q72-96h, if no alternative)	Not recommended (300 ^(viii) mg q7d, if no alternative)	300 ^(viii) mg q7d ^(iv)
ZDV		300 mg q12h	No dose adjustment required		100 mg q8h	100 mg q8h ^(iv)
ABC/3TC		600/300 mg q24h	Use individual drugs			
ZDV/3TC		300/150 mg q12h				
ABC/3TC/ZDV		300/150/300 mg q12h				
TAF/FTC		25 ^(ix) /200 mg q24h		Not recommended		
TDF/FTC		300 ^(viii) /200 mg q24h	300 ^(viii) /200 mg q48h	Use individual drugs		
NNRTIs						
EFV		600 mg q24h	No dose adjustment required			
ETV		200 mg q12h	No dose adjustment required			
NVP		200 mg q12h	No dose adjustment required			
TAF/FTC/RPV		25/200/25 mg q24h		Not recommended		
TDF/FTC/RPV		300 ^(viii) /200/25 mg q24h	Do not use			

eGFR ⁽ⁱ⁾ (mL/min)					Haemodialysis
	≥ 50	30-49	10-29	< 10	
PIs ^(v)					
ATV/c	300/150 mg q24h	No dose adjustment required ^(vi)			
ATV/r	300/100 mg q24h	No dose adjustment required ^(vi)			
DRV/r	800/100 mg q24h 600/100 mg q12h	No dose adjustment required ^(vi)			
DRV/c	800/150 mg q24h	No dose adjustment required ^(vi)			
TAF/FTC/DRV/c	10/200/800/150 mg q24h	Not recommended			
FPV/r	700/100 mg q12h	No dose adjustment required ^(vi)			
LPV/r	400/100 mg q12h	No dose adjustment required ^(vi)			
SQV/r	1000/100 mg q12h	No dose adjustment required ^(vi)			
TPV/r	500/200 mg q12h	No dose adjustment required ^(vi)			
Other ART					
RAL	1 x 400 mg tablet q12h or 2 x 600 mg tablets q24h	No dose adjustment required ^(vi)			
DTG	50 mg q24h	No dose adjustment required ^(vi)			No clinical data; PK data suggest safety
ABC/3TC/DTG	600/300/50 mg q24h	Use individual drugs			
TAF/FTC/BIC	20/200/75 mg q24h	Not recommended			
TAF/FTC/EVG/c	10/200/150/150 mg q24h		Not recommended		
TDF/FTC/EVG/c	Do not initiate if eGFR < 70 mL/min	Do not use			
MVC: co-administered without CYP3A4 inhibitors ^(vii)	300 mg q12h	No dose adjustment required ^(vi)			
MVC: co-administered with CYP3A4 inhibitors ^(vii)	If eGFR < 80 mL/min 150 mg q24h ^(vii) except: 150 mg q12h if co-administered with FPV/r				

i eGFR: Use CKD-EPI formula; the abbreviated modification of diet in renal disease (aMDRD) or the Cockcroft-Gault (CG) equation may be used as an alternative; see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>

ii Dose reduction if combined with TDF

iii 150 mg loading dose

iv After dialysis

v TDF and (boosted) PIs are associated with nephrotoxicity; consider alternative ART if pre-existing CKD, risk factors for CKD and/or decreasing eGFR, see [ARV-associated Nephrotoxicity and Kidney Disease: Definition, Diagnosis and Management](#)

vi Limited data available in persons with renal impairment; pharmacokinetic analysis suggests no dose adjustment required

vii See summary of product characteristics for specific recommendations; use with caution if eGFR ≤ 30 mL/min

viii In certain countries TDF is labelled as 245 mg rather than 300 mg to reflect the amount of the prodrug (tenofovir disoproxil) rather than the fumarate salt (tenofovir disoproxil fumarate)

ix 10 mg if co-administered with a boosting agent (inhibition of P-glycoprotein, P-gp)

Administration of ARVs in Persons with Swallowing Difficulties

Drug	Formulation	Crush tablets	Open capsules	Comment
NRTIs				
ABC	tablet (300 mg) solution (20 mg/mL)	yes		Bitter taste. Crushed tablets can be added to small amount of semi-solid food or liquid, all of which should be consumed immediately
d4T	capsule (20, 30, 40 mg) oral solution (1 mg/mL)	no	yes	Take on empty stomach
FTC	capsule (200 mg) solution (10 mg/mL)	no	yes	Dissolve in ≥ 30 mL of water, contains Na 460 $\mu\text{mol/mL}$ Bioequivalence: 240 mg solution = 200 mg capsule; adjust dosage accordingly
3TC	tablet (150, 300 mg) solution (10 mg/mL) ^(vii)	yes		Crushed tablets can be added to small amount of semi-solid food or liquid, all of which should be consumed immediately
TDF	tablet (300 ⁽ⁱ⁾ mg)	yes		Better: dissolve in ≥ 1 dL of water/orange or grape juice (bitter taste)
ZDV	capsule (250 mg) syrup (10 mg/mL)	no	no	Sticky, bitter taste Better: use syrup or iv 6 mg/kg per day in glucose 5%
TAF/FTC	tablet (25/200 mg and 10/200 mg) ^(v)	yes		Crushing of tablets is not recommended in the product information. However based on data with the fixed-dose combination tablet (TAF/FTC/DRV/c/), crushing of tablets does not impact significantly TAF/FTC pharmacokinetics (of note: TAF bioavailability is reduced by 20% (crushing) but this decrease is unlikely to be clinically significant) ^(viii)
TDF/FTC	tablet (300 ⁽ⁱ⁾ /200 mg)	yes		Better: dissolve in ≥ 1 dL of water/orange or grape juice (bitter taste)
ABC/3TC	tablet (600/300 mg)	no		Use solution of individual compounds
ZDV/3TC	tablet (300/150 mg)	yes		Disperse in ≥ 15 mL water, alternative: use solution of individual compounds
ABC/3TC/ZDV	tablet (300/150/300 mg)	no		Use solution of individual compounds
NNRTIs				
EFV	tablet (600 mg)	yes		Difficult to dissolve; solution has lower bioavailability; if > 40 kg use 720 mg
	capsule (50, 100, 200 mg)	no	yes	
	solution (30 mg/mL)			
ETV	tablet (200 mg)	no		Disperse in ≥ 5 mL water. The glass should be rinsed with water several times and each rinse completely swallowed to ensure the entire dose is consumed.
NVP	tablet (200, 400 mg) ⁽ⁱⁱ⁾ suspension (10 mg/mL)	yes ⁽ⁱⁱ⁾		Dissolve in water
RPV	tablet (25 mg)	no		Crushing of tablets and dispersion into a liquid is not recommended. RPV is insoluble in water over a wide pH range
TDF/FTC/EFV	tablet (300 ⁽ⁱ⁾ /200/600 mg)	no		
TAF/FTC/RPV	tablet (25/200/25 mg) ^(v)	no		Tablets should be swallowed whole and should not be chewed, crushed or split
TDF/FTC/RPV	tablet (300 ⁽ⁱ⁾ /200/25 mg)	no		Crushing of tablets and dispersion into a liquid is not recommended. RPV is insoluble in water over a wide pH range.
PIs				
ATV	capsule (150, 200, 300 mg)	no	no	Do not open the capsule, swallow whole
ATV/c	tablet (300/150 mg)	no		Tablets should be swallowed whole and should not be chewed, broken, cut or crushed
DRV	tablet (75, 150, 400, 600, 800 mg) solution (100 mg/mL)	yes		Take with food. Crushed tablets can be added to small amount of semi-solid food or liquid, all of which should be consumed immediately
DRV/c	tablet (800/150 mg)	yes		Crushing of tablets is not recommended in the product information. However, based on data with the fixed-dose combination tablet (TAF/FTC/ DRV/c), crushing of tablets does not impact significantly DRV/c pharmacokinetics ^(viii)
FPV	tablet (700 mg) suspension (50 mg/mL)			Bitter taste; adults take suspension on empty stomach
LPV/r	tablet (200/50 mg) solution (80/20 mg/mL)	no		42% alcohol, do not dilute with water (risk of precipitation), rinse with milk (no water); take with food, bitter taste: dilute with chocolate milk
RTV	tablet (100 mg) solution (80 mg/mL)	no		43% alcohol, do not dilute solution (risk of precipitation), rinse with milk (no water); bitter taste; take with food
SQV	tablet (500 mg)	no		
TAF/FTC/DRV/c	tablet (10/200/800/150 mg) ^(v)	yes		Crushing of tablets has no significant effect on the pharmacokinetics of the components of the tablet (of note: TAF bioavailability is reduced by 20% (crushing) but this decrease is unlikely to be clinically significant. TAF bioavailability is not changed when splitting the pill) ^(viii)
Others				
DTG	tablet (50 mg)	yes		Tablets may be split or crushed and added to a small amount of semi-solid food or liquid, all of which should be consumed immediately
MVC	tablet (150, 300 mg)	yes		While the company does not have any specific kinetic information, crushing the tablet is not expected to negatively affect the bioavailability
RAL ⁽ⁱⁱⁱ⁾	tablet (400 mg) chewable tablets (25, 100 mg)	yes		The bioavailability of the chewable tablet is higher: 300 mg chewable tablet (= 400 mg film-coated tablet)

Drug	Formulation	Crush tablets	Open capsules	Comment
RPV/DTG	tablet (25/50 mg)	no		Tablets should be swallowed whole and should not be chewed, crushed or split
TAF/FTC/BIC	tablet (25/200/50 mg) ^(vi)	no		Tablets should be swallowed whole and should not be chewed, crushed or split
TAF/FTC/EVG/c	tablet (10/200/150/150 mg) ^(vi)	yes		Crushing of tablets is not recommended in the product information. However, based on data with the fixed-dose combination tablet (TAF/FTC/DRV/c), crushing of tablets does not impact significantly TAF/FTC pharmacokinetics (of note: TAF bioavailability is reduced by 20% (crushing) but this decrease is unlikely to be clinically significant) ^(viii) . Similarly, crushing of /TDF/FTC/ EVG/c did not have a significant effect of the pharmacokinetics of EVG/c ^(iv)
TDF/FTC/EVG/c	tablet (300 ⁽ⁱⁱ⁾ /200/150/150 mg)	yes		Crushing of tablets does not significantly modify the pharmacokinetic profiles ^(iv)
ABC/3TC/DTG ^(vi)	tablet (600/300/50 mg)	yes		Tablets may be split or crushed and added to a small amount of semi-solid food or liquid, all of which should be consumed immediately
Prophylaxis/treatment of opportunistic infections				
azithromycin	tablet (250, 500 mg) suspension (40 mg/mL)	no		
cotrimoxazole	tablet (400/80 mg, forte 800/160 mg) solution (40/8 mg/mL)	yes; forte difficult		Dilute solution 3-5 times with water (high osmolality)
fluconazole	capsule (50, 200 mg) suspension (40 mg/mL)	no	yes	
pyrimethamine	tablet (25 mg)	yes		Take with food
valganciclovir	tablet (450 mg) solution (50 mg/mL)	no	no	Difficult to dissolve
rifampicin	tablet (450, 600 mg)	yes		Take on empty stomach
	capsule (150, 300 mg)	no	yes	
	suspension (20 mg/mL)			
rifabutin	capsule (150 mg)	no	yes	Mix with apple sauce, syrup (insoluble in water)
isoniazid	tablet (100, 150 mg)	yes		Take on empty stomach
pyrazinamide	tablet (500 mg)	yes		
ethambutol	tablet (100, 400 mg)	yes		Difficult to dissolve Better: use iv solution
rifampicin/isoniazid	tablet (150/100, 150/75 mg)	yes		Take on empty stomach
Rifater (rifampicin, isoniazid, pyrazinamide)	tablet (120/50/300 mg)	yes		Take on empty stomach
Rimstar (rifampicin, isoniazid, pyrazinamide, ethambutol)	tablet (150/75/400/275 mg)	yes		Take on empty stomach
ribavirin	capsule (200 mg)	no	yes	Disperse in orange juice, take with food

For recommendations on prophylaxis/treatment of opportunistic infections, see [Part V Opportunistic Infections](#)

- i In certain countries TDF is labelled as 245 mg rather than 300 mg to reflect the amount of the prodrug (tenofovir disoproxil) rather than the fumarate salt (tenofovir disoproxil fumarate).
- ii Extended release effect lost. Note: NVP 400 mg qd (immediate release) can lead to sub-therapeutic trough levels in individuals with higher body weight (≥ 90 kg) compared to NVP 200 mg bid. Therefore, NVP bid administration should be preferred in individuals with higher body weight.
- iii Crushing tablets is not recommended in the product information, however absorption of RAL was not compromised when the drug was crushed, dissolved in 60 mL warm water and administered by gastrostomy tube [10]. In addition, RAL drug absorption has been shown to be higher in HIV-positive persons taking RAL 400 mg bid by chewing the tablets as compared to swallowing the intact tablets [11].

- iv Crushing tablets is not recommended in the product information however the pharmacokinetic profiles of TDF/FTC/EVG/c were not significantly modified when the fixed-dose combination tablet (Stribild) was crushed and administered with food or with drip feed compared to the administration of the whole tablet [12].
- v TAF is used at 10 mg when co-administered with drugs that inhibit P-gp. TAF is used at 25 mg when co-administered with drugs that do not inhibit P-gp.
- vi The pharmacokinetic profiles of ABC/3TC/DTG were not modified to a clinically significant extent when the fixed-dose combination tablet (Triumeq) was crushed and administered suspended in water or in enteral nutrition (of note: crushing leads to a 26% increase in DTG exposure) [14].
- vii The bioavailability of 3TC solution has been shown to be significantly reduced in a dose dependent manner by sorbitol present in other liquid formulations (e.g. ABC, NVP, cotrimoxazole) [15].
- viii Crushing of tablets is not recommended in the product information, however the individual pharmacokinetic profiles of TAF/FTC/ DRV/c were not significantly modified when the fixed-dose combination tablet (Symtuza) was administered crushed or split compared to the whole tablet [16].

Part III Prevention and Management of Co-morbidities in HIV-positive Persons

The appropriate management of co-morbidities, which include cardiovascular, pulmonary, hepatic, metabolic, neoplastic, renal, bone, central nervous system disorders as well as sexual dysfunction, has increasingly become an integral part of the overall management of individuals living with HIV.

Potential contributors to co-morbidity pathogenesis include a higher prevalence of recognised risk factors, ART-exposure and toxicity, HIV itself as well as immune dysfunction/dysregulation and chronic immune activation/inflammation, associated with HIV or other co-infections (e.g. CMV, HCV).

Health care professionals other than HIV specialists, who are involved in the care of HIV-positive persons and who are not familiar with the use of ART, should consult their HIV specialist colleagues before introducing or modifying any type of medicines for co-morbidity. As intervals between visits to HIV-clinics are increasingly extended, HIV-positive persons can be expected to seek care more frequently with their primary care doctor. In these situations, it is important to ensure some level of shared-care arrangement.

Conversely, many HIV doctors are not specialists in managing co-morbidities, and should seek expert advice where appropriate in the prevention and management of such conditions. Situations where consultation is generally recommended are indicated elsewhere in this document.

As individuals with treated HIV age, complex multiple co-morbidities often co-exist in the same person and may be associated with frailty and disability. Such circumstances may require a comprehensive “geriatric-type” multidimensional, multidisciplinary assessment aimed at appropriately capturing the composite of medical, psychosocial and functional capabilities and limitations of elderly HIV-positive persons.

Depending on future clinical research findings, these recommendations will be regularly updated as required. The online version at <http://www.eacso-ciety.org> and the EACS Guidelines App contain more detailed information and links to other relevant websites; these will be regularly updated. The current recommendations highlight co-morbidities that are seen frequently in the routine care of HIV-positive persons and those for which specific issues should be considered.

Drug Dependency and Drug Addiction

Characteristics of drugs used as opioid substitution therapy (OST)⁽ⁱ⁾

Feature	Methadone	Buprenorphine
Dose required to prevent withdrawal symptoms according to degree of opioid dependency	Linear relationship (from 10-300 mg per day)	Linear relationship for persons with less opioid dependency only – ceiling effect (max daily dose 24 mg)
Interaction with ARVs	Methadone plasma concentrations are reduced if used together with NNRTIs or PIs: <ul style="list-style-type: none"> • NVP & EFV: ↓ 50% • ETV: ↓ < 10%⁽ⁱⁱ⁾ • LPV/r: ↓ 50% • SQV/r, DRV/r, FPV/r: ↓ 15-25% • ATV, IDV: ↓ < 10% 	Buprenorphine (B) and active metabolite norbuprenorphine (N) plasma concentrations are reduced if combined with NNRTIs and increased if combined with some PIs or INSTIs <ul style="list-style-type: none"> • EFV: ↓ up to 50% (B) and 70% (N) • ETV: ↓ 25% (B) • ATV/r, IDV, SQV/r: ↑ 50-100% (B&N) • DRV/r: ↑ 50% (N) • CAVE: B reduces ATV; do not use without RTV or COBI boosting • EVG/c, ↑ 35-42% (B&N) (BIC, DTG, RAL, RPV & LPV/r do not affect B & N metabolism)
	CAVE: withdrawal symptoms if combined with ARV that decreases plasma concentration and risk of drug toxicity if such ARVs are interrupted – reverse if ARVs increase plasma concentration	
Risk of overdose	Yes	No, if used as a co-formulation with naloxone
Causing QT prolongation on ECG	Yes (dose-response relationship) ⁽ⁱⁱⁱ⁾	No
Risk of obstipation	High	High
Type of administration	Tablet or liquid	Tablet applied sublingual
Risk of further impairment in persons with existing liver impairment	Yes	Yes

i See [Drug-drug Interactions between Analgesics and ARVs](#)

ii Note that despite ETV causes a decrease in the plasma concentration of methadone, the active methadone enantiomer is in fact increased 6% by ETV.

iii ECG recommended for daily methadone doses exceeding 50 mg; special caution with concomitant use of other drugs known to cause QT prolongation (e.g. certain PIs such as SQV/r as well as albuterol (USAN) or salbutamol (INN), amiodarone, amitriptyline, astemizole, chloroquine, clomipramine and moxifloxacin).

Cancer: Screening Methods⁽ⁱ⁾

Problem	Persons	Procedure	Evidence of benefit	Screening interval	Additional comments
Anal cancer	MSM and persons with HPV-associated dysplasia ⁽ⁱⁱ⁾	Digital rectal exam ± anal cytology	Unknown; advocated by some experts	1-3 years	If anal cytology abnormal, anoscopy
Breast cancer	Women 50-70 years	Mammography	↓ Breast cancer mortality	1-3 years	
Cervical cancer	HIV-positive women > 21 years or within 1 year after sexual debut	Liquid based cervical cytology test	↓ Cervical cancer mortality	1-3 years	HPV testing may aid screening
Colorectal cancer	Persons 50-80 years with a life expectancy > 10 years	Faecal occult blood test annually or sigmoidoscopy every 5 years or colonoscopy every 10 years	↓ Colorectal cancer mortality	1-3 years	
HepatoCellular Carcinoma (HCC)	Persons with cirrhosis, persons with HBV co-infection at high risk of HCC or those who ever had chronic hepatitis ⁽ⁱⁱⁱ⁾	Ultrasound (and alpha-fetoprotein)	Earlier diagnosis allowing for improved ability for surgical eradication	Every 6 months	See pages 58 and 81
Prostate cancer	Men > 50 years with a life expectancy >10 years	PSA ^(iv)	Use of PSA is controversial	2-4 years	Pros: ↑ early diagnosis and modest ↓ prostate cancer specific mortality. Cons: overtreatment, adverse effects of treatment on quality of life

- i Screening recommendations derived from the general population. These screenings should preferably be done as part of national general population-screening programmes. Careful examination of skin should be performed regularly to detect cancers such as Kaposi's sarcoma, basal cell carcinoma and malignant melanoma.
- ii Includes Anal Intraepithelial Neoplasia (AIN), Penile Intraepithelial Neoplasia (PIN), Cervical Intraepithelial Neoplasia (CIN), Vaginal Intraepithelial Neoplasia (VAIN) and Vulval Intraepithelial Neoplasia (VIN).
- iii HCC screening is indicated in all cirrhotic HBV or HCV co-infected persons (even if HCV infection has been cured and HBV replication is medically suppressed) in a setting where treatment for HCC is available. Although the cost-effectiveness of HCC screening in persons with F3 fibrosis is uncertain, surveillance may be considered based on an individual risk assessment (www.easl.eu/research/our-contributions/clinical-practice-guidelines/detail/easl-clinical-practice-guidelines-on-hepatocellular-carcinoma). In HBV-positive non-cirrhotics, HCC screening should follow current EASL guidelines. Risk factors for HCC in this population include family history of HCC, ethnicity (Asians, Africans), HDV and age. EASL guidelines propose using the PAGE-B score in Caucasians to assess the HCC risk, however this score has not been validated in HIV-positive persons, see pages 58 and 81.
- iv Whilst prostate cancer screening with PSA can reduce prostate cancer specific mortality, the absolute risk reduction is very small. Given limitations in the design and reporting of the randomized trials, there remain important concerns that the benefits of screening are outweighed by the potential harms to quality of life, including the substantial risks for over-diagnosis and treatment complications.

See online video lectures [Epidemiology of cancers and HIV-Part 1](#), [Epidemiology of cancers and HIV-Part 2](#), [Clinical Management of cancers and HIV-Part 1](#) and [Clinical Management of cancers and HIV-Part 2](#) from the EACS online course Clinical Management of HIV.

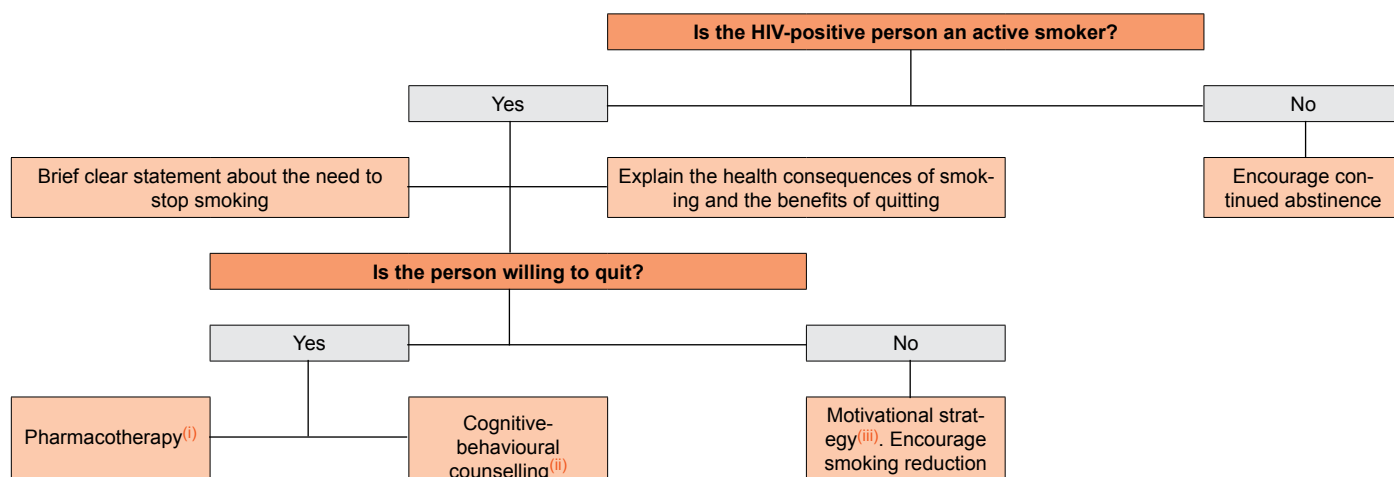
Lifestyle Interventions⁽ⁱ⁾

Dietary counselling	<ul style="list-style-type: none"> • Dietary intervention should not interfere with the dietary requirements necessary for appropriate absorption of ART drugs • Keep caloric intake balanced with energy expenditure • Limit intake of saturated fat, cholesterol and refined carbohydrates • Reduce total fat intake to < 30% and dietary cholesterol to < 300 mg/day • Emphasise intake of vegetables, fruit and grain products with fibre • Cut back on beverages and foods with added sugar • Choose and prepare foods with little or no salt. Aim to eat less than 1,500 mg of sodium per day • Emphasise consumption of fish, poultry (without skin) and lean meat • Consider referral to dietician, one-week food and drink diary to discover 'hidden' calories • Avoid binge eating ('yo-yo dieting') • In persons with HIV-related wasting and dyslipidaemia, address wasting first and consider referral to dietician • Persons who are obviously overweight should be motivated to lose weight. Starvation diets are not recommended (immune defence mechanisms potentially decreased). Malnutrition has to be addressed where observed. Normal BMI range: 18.5-24.9; Overweight: 25.0-29.9, Obesity: > 30.0 kg/m²
Exercise promotion	<ul style="list-style-type: none"> • The following questions are helpful to determine average alcohol intake <ol style="list-style-type: none"> 1. How often do you drink alcohol: never, ≤ 1/month, 2-4x/month, 2-3x/week, > 4x/week 2. If you drink alcohol, how much typically at a time: 1-2, 3-4, 5-6, 7-9, > 10 drinks 3. How many times do you have 6 or more alcoholic drinks at one occasion: never, < 1/month, 1x/month, 1x/week, more or less daily. • Intake of alcohol should be restricted to no more than one drink per day for women and two drinks per day for men (< 20-40 g/day). • In particular, persons with hepatic disease, see NAFLD, adherence problems, inadequate CD4 count increase, tumours, past tuberculosis, diarrhoea and other conditions associated with high alcohol intake should be motivated to decrease or stop alcohol intake.

ⁱ Based on recommendations by the US Preventive Services Task Force

Smoking cessation

HIV-positive tobacco users should be made aware of the substantial health benefits of smoking cessation which include reducing the risk of tobacco-related diseases, slowing the progression of existing tobacco related disease, and improving life expectancy by an average of 10 years. Regularly consider the following algorithm with two major questions:



Adapted from [1] and [2]

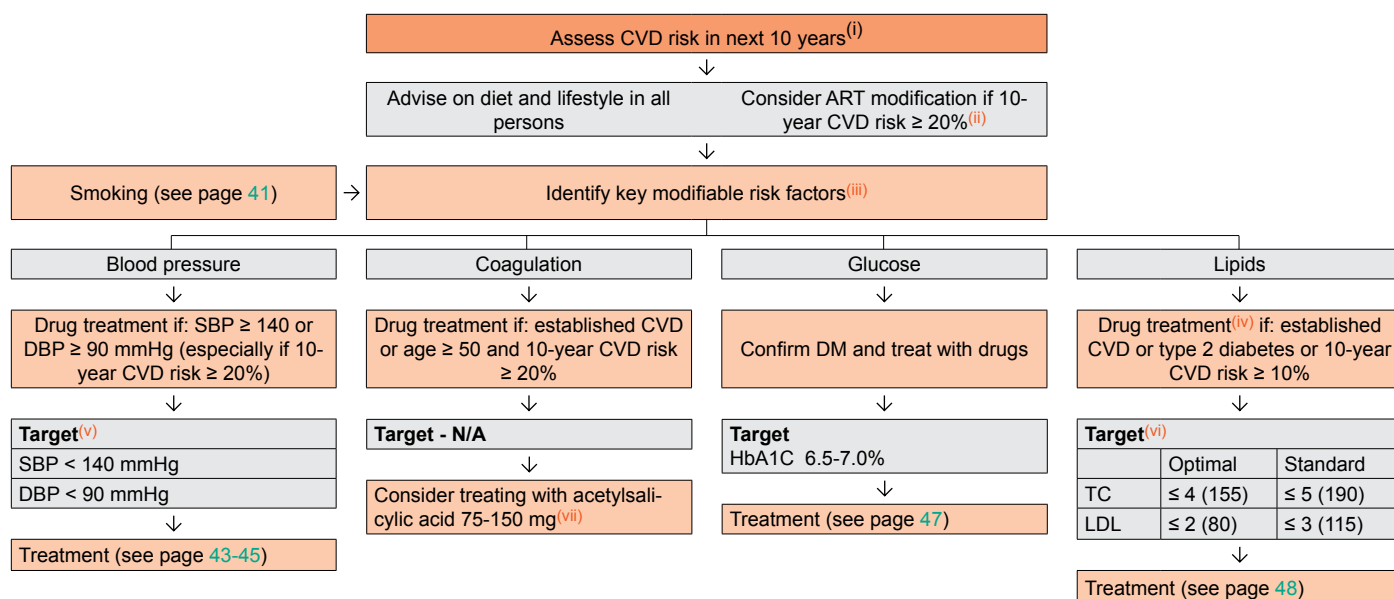
ⁱ Pharmacotherapy: Nicotine replacement therapy: nicotine substitution (patch, chewing gum, spray), varenicline and bupropion are approved by the EMA. Bupropion is contraindicated with epilepsy and varenicline may induce depression. Bupropion may interact with PIs and NNRTIs, see [Drug-drug Interactions between ARVs and Non-ARVs](#)

ⁱⁱ Cognitive-behavioral counselling: Use specific available resources. Either individual or group interventions to better suit and satisfy the HIV-positive person. The programme should consist of four or more sessions lasting 30 minutes for 3-4 months.

ⁱⁱⁱ Motivational strategy: Identify potential health risks of the smoker and to stratify both acute (e.g. exacerbations of COPD) and long-term (e.g. infertility, cancer) risks. Show the HIV-positive person the personal benefits of stopping smoking. Identify the barriers or obstacles that might impede the success of a quit attempt. Smoking cessation interventions should be delivered repeatedly, as long as the HIV-positive person is not willing/ready enough to quit smoking.

Prevention of CVD

Principles: The intensity of efforts to prevent CVD depends on the underlying risk of CVD, which can be estimated⁽ⁱ⁾. The preventive efforts are diverse in nature and require involvement of a relevant specialist, in particular if the risk of CVD is high and always in persons with a history of CVD.



- i** Use the Framingham equation or whatever system local National Guidance recommends; a risk equation developed from HIV populations is available: see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>. This assessment and the associated considerations outlined in this figure should be repeated annually in all persons under care, see pages 6-8, to ensure that the various interventions are initiated in a timely way.
- ii** Options for ART modification include:
- (1) Replace with NNRTI, INSTI or another PI/r known to cause less metabolic disturbances and/or lower CVD risks, see pages 21-22
 - (2) Consider replacing ZDV or ABC with TDF or use an NRTI-sparing regimen
- iii** Of the modifiable risk factors outlined, drug treatment is reserved for certain subgroups where benefits are considered to outweigh potential harm. Of note, there is a combined benefit of various interventions in target groups identified. Per 10 mmHg reduction in systolic blood pressure, per 1 mmol/L (39 mg/dL) reduction in TC and with use of acetylsalicylic acid, each reduces risk of IHD by 20-25%; the effect is additive. Observational studies suggest that smoking cessation results in about 50% less risk of IHD – and this is additive to other interventions.

- iv** See discussion on drug treatment of persons with lower CVD risk at <https://www.nhlbi.nih.gov/files/docs/guidelines/atp3xsum.pdf>
- v** For higher risk individuals (e.g. diabetes) where resources allow target SBP < 130 and DBP < 80 mmHg.
- vi** Target levels are to be used as guidance and are not definitive – expressed as mmol/L with mg/dL in parenthesis. In case LDL cannot be calculated because of high triglyceride levels, the non-HDL-c (TC minus HDL-c) target should be used which is 0.8 mmol/L (30 mg/dL) higher than the corresponding LDL-c target. Target levels for TG are not listed because an independent contribution from TG to CVD risk is uncertain, and hence whether this condition should be treated, see page 48.
- vii** Evidence for benefit when used in persons without a history of CVD (including diabetics) is less compelling. BP should be reasonably controlled before aspirin use in such a setting.

See online video lecture [CVD, CKD, Endocrinology](#) from the EACS online course Clinical Management of HIV.

Hypertension: Diagnosis, Grading and Management

Other risk factors, asymptomatic organ damage or disease	Blood pressure (mmHg)	Blood pressure (mmHg)	Blood pressure (mmHg)	Blood pressure (mmHg)
	High normal SBP 130-139 or DBP 85-89	Grade 1 hypertension SBP 140-159 or DBP 90-99	Grade 2 hypertension SBP 160-179 or DBP 100-109	Grade 3 hypertension SBP ≥ 180 or DBP ≥ 110
No other risk factors	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ No BP drug intervention 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ for several months Then add BP drugs targeting < 140/90 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ for several weeks Then add BP drugs targeting < 140/90 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Immediate BP drugs targeting < 140/90
1-2 risk factors	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ No BP drug intervention 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ for several weeks Then add BP drugs targeting < 140/90 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ for several weeks Then add BP drugs targeting < 140/90 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Immediate BP drugs targeting < 140/90
≥ 3 risk factors	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ i.e. no BP drug intervention 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ for several weeks Then add BP drugs targeting < 140/90 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ BP drugs targeting < 140/90 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Immediate BP drugs targeting < 140/90
Organ damage, CKD stage 3 or diabetes	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Consider blood pressure drugs targeting < 130/80 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ BP drugs targeting < 140/90⁽ⁱⁱ⁾ 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ BP drugs targeting < 140/90⁽ⁱⁱ⁾ 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Immediate BP drugs targeting < 140/90⁽ⁱⁱ⁾
Symptomatic CVD, CKD stage ≥ 4 or diabetes with organ damage/risk factors	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Consider blood pressure drugs targeting < 130/80 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ BP drugs targeting < 140/90⁽ⁱⁱ⁾ 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ BP drugs targeting < 140/90⁽ⁱⁱ⁾ 	<ul style="list-style-type: none"> Lifestyle changes⁽ⁱ⁾ Immediate BP drugs targeting < 140/90⁽ⁱⁱ⁾

BP blood pressure
DBP diastolic blood pressure
SBP systolic blood pressure

Repeated blood pressure measurements should be used for stratification

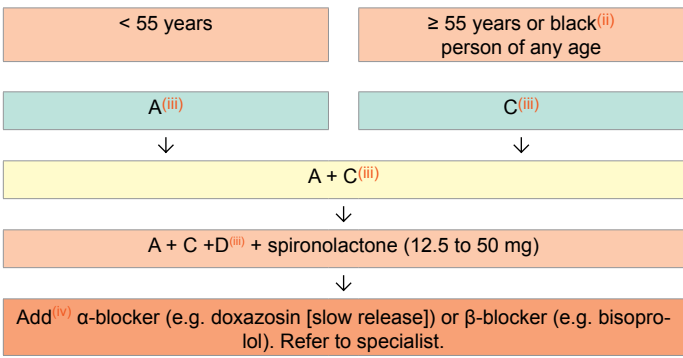
ⁱ Recommended lifestyle interventions, see page 41

ⁱⁱ Consider targeting < 130/80 when resources allow

Table adapted from [3].

Hypertension: Drug Sequencing Management

Choosing drugs ⁽ⁱ⁾ for persons newly diagnosed with hypertension



Abbreviations + details

- A ACE inhibitor (e.g. perindopril, lisinopril or ramipril) or low cost angiotensin receptor blockers (ARB) (e.g. losartan, candesartan)
- C Dihydropyridine calcium-channel blocker (e.g. amlodipine). If not tolerated or if deemed at high risk of heart failure, 'D' drugs can be used instead. Where a C drug is preferred but not tolerated, verapamil or diltiazem may be used (note: dose with caution with PIs as these may increase plasma concentrations of these calcium-channel blockers, potentially leading to toxic reactions)
- D Thiazide-type diuretic* e.g. indapamide or chlorthalidone as a first choice
- ⁱ Some calcium-channel blockers interact marginally with the pharmacokinetics of ARVs, see [Drug-drug Interactions between Antihypertensives and ARVs](#)
- ⁱⁱ Black persons are those of African or Caribbean descent, and not mixed race, Asian or Chinese persons. Single tablet combinations of antihypertensive drugs (where available) are increasingly recommended both as first-line therapy (A + C or A + D) and second-line therapy
- ⁱⁱⁱ Wait 4-6 weeks to assess whether target, see page 42, is achieved; if not, go to next step
- ^{iv} Requirement of 4-5 drugs to manage hypertension needs specialist training
- * This excludes thiazides (e.g. hydrochlorothiazide (HCTZ), bendroflumethiazide etc.). However, if thiazide-type diuretics are not available low-dose thiazides may be used as a treatment alternative.

Drug-drug Interactions between Antihypertensives and ARVs

Antihypertensives		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
ACE inhibitors	captopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	cilazapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	enalapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	lisinopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	perindopril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	quinapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	ramipril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	trandolapril	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Angiotensin antagonists	candesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	eprosartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	irbesartan	↔	↓	↔	↓	↓	↑	↑	↔	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
	losartan	↔	↓ ^a	↔	↓ ^a	↓ ^a	↑ ^b	↑ ^b	↔	↔	↔	↔	↔	↓ ^a	↔	↔	↔	↔	↔	↔
	olmesartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	telmisartan	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	valsartan	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
β blockers	atenolol	↔ ^d	↔ ^d	↔	↔	↔ ^d	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bisoprolol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	carvedilol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↑	↑	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	metoprolol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	propranolol	↑ ^d	↑ ^d	↑	↑	↑ ^d	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	atenolol	↔ ^d	↔ ^d	↔	↔	↔ ^d	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Calcium channel blockers	amlodipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	diltiazem	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓69%	↓E	↓	E	E	E	↔	↑	↔	↔	↔	↔	↔	↔
	felodipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lacidipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	lercanidipine	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nicardipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓E	↓	E	E	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nifedipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	nisoldipine	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	verapamil	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓E	↓	E	E	E	↔	↑	↔	↔	↔	↔	E	E
	verapamil	↑ ^c	↑ ^c	↑	↑	↑ ^e	↓	↓E	↓	E	E	E	↔	↑	↔	↔	↔	↔	E	E
Diuretics	amiloride	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bendroflumethiazide	?	?	?	?	?	?	?	?	↔	↔	↔	↔	?	↔	↔	↔	↔	↔	↔
	chlortalidone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	furosemide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E
	indapamide	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	hydrochlorothiazide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	torasemide	↔	↓	↔	↓	↓	↑	↑	↔	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔
Others	doxazosin	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sacubitril	↑	↑	↑	↑	↑	↔	↔	↔	↔	E	↔	↔	↔	↔	↔	↔	↔	↔	↑
	spironolactone	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of the antihypertensive
- ↓ potential decreased exposure of the antihypertensive
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a [parent drug] decreased but [active metabolite] increased
- ^b [parent drug] increased but [active metabolite] decreased
- ^c ECG monitoring recommended
- ^d risk of PR interval prolongation
- ^e use with caution as both LPV and calcium channel blockers prolong the PR interval. Clinical monitoring is recommended.

Numbers refer to decreased AUC of the antihypertensive as observed in drug-drug interactions studies.

Note: no clinically significant interactions expected between ZDV and antihypertensives

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required
- there are no clear data, actual or theoretical, to indicate whether an interaction will occur

Note: although some drug interactions are predicted to potentially require a dosage adjustment based on the drug's metabolic pathway, clinical experience with a particular antihypertensive and ARV drug may indicate that dosage adjustments are not an *a priori* requirement.

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Type 2 Diabetes: Diagnosis

Diagnostic criteria⁽ⁱ⁾

	Fasting plasma glucose mmol/L (mg/dL) ⁽ⁱⁱ⁾	Oral glucose tolerance test (OGTT) 2-h value mmol/L (mg/dL) ⁽ⁱⁱⁱ⁾	HbA1c ^(iv) (mmol/mol)
Diabetes	≥ 7.0 (126) OR→	≥ 11.1 (200)	≥ 6.5% (≥ 48)
Impaired glucose tolerance (IGT)	< 7.0 (126) AND→	7.8 – 11.0 (140-199)	Prediabetes 5.7-6.4% (39-47)
Impaired fasting glucose (IFG)	5.7– 6.9 AND (100-125)	< 7.8 (140)	

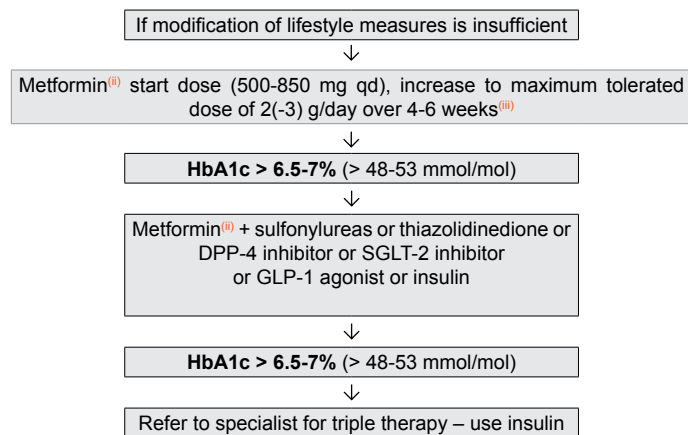
i As defined by WHO, [4] and [5]

ii An abnormal finding should be repeated before confirming the diagnosis

iii Recommended in persons with fasting blood glucose of 5.7 - 6.9 mmol/L (100-125 mg/dL) as it may identify persons with overt diabetes

iv Do not use HbA1c in presence of haemoglobinopathies, increased erythrocyte turnover and severe liver or kidney dysfunction. Falsely high values are measured under supplementation with iron, vitamin C and E as well as older age (age > 70: HbA1c + 0.4%). HbA1c values in treated HIV-positive persons, particularly when on ABC, tend to underestimate type 2 diabetes. Both IGT and IFG increase CVD morbidity and mortality, and increase the risk of developing diabetes by 4-6 fold. These persons should be targeted for lifestyle intervention, and their CVD risk factors must be evaluated and treated.

Type 2 Diabetes⁽ⁱ⁾: Management



Treatment goals:

Prevention of hyper-/hypoglycaemia, glucose control (HbA1c < 6.5-7% without hypoglycaemia, fasting plasma glucose 4-6 mmol/L (73-110 mg/dL), prevention of long-term complications.

- Normal blood lipids, see pages 42 and 48, and blood pressure < 130/80 mmHg, see page 43.
- Acetylsalicylic acid (75-150 mg qd) considered in diabetics with elevated underlying CVD risk, see page 42.
- Nephropathy, polyneuropathy and retinopathy screening should be performed as in diabetic persons without HIV
- Consultation with a specialist in diabetology is recommended

i Type 1 diabetes should be treated according to national guidelines.

ii Metformin may worsen lipoatrophy.

No data for any oral antidiabetic agents in terms of CVD prevention in HIV-positive persons. Incretins (DPP-4 inhibitors [e.g. linagliptin, saxagliptin (reduce dose when given with a booster), sitagliptin and vildagliptin], GLP-1 agonists [liraglutide, exenatide], and SGLT-2 inhibitors [e.g. dapagliflozin, canagliflozin, empagliflozin] have not been evaluated in HIV-positive persons, but some (e.g. empagliflozin, liraglutide) have shown to reduce mortality from CVD; choice of drugs dependent on a variety of individual- & disease-specific factors; no clinically significant drug-drug-interaction or adverse effects on CD4 counts expected; clinical use of pioglitazone questioned by its side effects; HbA1c targets up to 7.5% can be considered for older persons with long-standing type 2 diabetes and evidence of CVD.

iii Consider lower dose in individuals with mild to moderate CKD or individuals receiving DTG.

Dyslipidaemia

Principles: Higher LDL-c levels increase risk of CVD and reduction diminishes this risk (see table below for drugs used on this indication); the reverse is probably true for HDL-c but trial data are less compelling. The CVD risk implications from higher than normal TG levels are even less clear, as TG has not consistently been shown to independently predict the risk of CVD. Furthermore, the clinical benefit of treating moderate hypertriglyceridaemia is uncertain; very high TG (> 10 mmol/L or > 900 mg/dL) increase risk of pancreatitis.

Less calories, more exercise, reducing bodyweight, and stopping smoking tend to improve (increase) HDL. Eating fish, reducing calories, saturated fat and alcohol intake reduce triglyceride levels. Reducing dietary saturated fat intake improves LDL-levels; if not effective, consider change of ART, then consider lipid-lowering medicine, see page 42. Statins should be used by all those with established vascular disease and among those with type 2 diabetes or at high risk of CVD, irrespective of lipid levels.

Drugs used to lower LDL-c

Drug class	Drug	Dose	Side effects	Advise on use of statin together with ART	
				use with PI/r	use with NNRTIs
Statin ^(i,ix)	atorvastatin ⁽ⁱⁱ⁾	10-80 mg qd	Gastrointestinal symptoms, headache, insomnia, rhabdomyolysis (rare) and toxic hepatitis	Start with low dose ^(v) (max: 40 mg)	Consider higher dose ^(vi)
	fluvastatin ⁽ⁱⁱⁱ⁾	20-80 mg qd		Consider higher dose ^(vi)	Consider higher dose ^(vi)
	pravastatin ⁽ⁱⁱⁱ⁾	20-80 mg qd		Consider higher dose ^(vi,vii)	Consider higher dose ^(vi)
	rosuvastatin ⁽ⁱⁱ⁾	5-40 mg qd		Start with low dose ^(v) (max: 20 mg)	Start with low dose ^(v)
	simvastatin ⁽ⁱⁱ⁾	10-40 mg qd		Contraindicated	
Intestinal cholesterol absorption inhibitor ^(i,viii)	ezetimibe ^(iv)	10 mg qd	Gastrointestinal symptoms	No known drug-drug interactions with ART	
PCSK9-inhibitor ^(x)	evolocumab	140 mg 2 weekly or 420 mg monthly	Nil	No drug-drug interactions anticipated	

- i** A statin is preferred first-line therapy; different statins have variable intrinsic LDL-c lowering ability
- ii, iii, iv** Target levels for LDL-c, see page 42. In persons where LDL-c targets are difficult to achieve, consult/refer to specialist
Expected range of reductions of LDL-c: **ii** 1.5-2.5 mmol/L (60-100 mg/dL), **iii** 0.8-1.5 mmol/L (35-60 mg/dL), **iv** 0.2-0.5 mmol/L (10-20 mg/dL)
- v, vi** The ARV may **v** inhibit (statin toxicity, ↓ dose) or **vi** induce (=less effect of statin, ↑ dose gradually to achieve expected benefit **ii, iii**) the excretion of the statin
- vii** **Exception:** If used with DRV/r, start with lower dose of pravastatin
- viii** This agent can be used for HIV-positive persons intolerant of statins or added to a statin when LDL reduction is inadequate despite maximally tolerated statin
- ix** Pitavastatin has as yet no morbidity/mortality trial data to support its use but may have advantages of fewer drug-drug interactions, more HDL increase and less adverse glucose effect than other statins
- x** Consider for highest risk individuals inadequately controlled on top statin dose or for statin intolerant individuals

Bone Disease: Screening and Diagnosis

Condition	Characteristics	Risk factors	Diagnostic tests												
Osteoporosis <ul style="list-style-type: none">• Postmenopausal women and men aged ≥ 50 years with BMD T-score ≤ -2.5• Premenopausal women and men aged < 50 years with BMD Z-score ≤ -2 and fragility fracture	<ul style="list-style-type: none">• Reduced bone mass• Increased incidence of fractures in HIV-positive persons• Asymptomatic until fractures occur <p>Common in HIV</p> <ul style="list-style-type: none">• Up to 10-15% prevalence of osteoporosis• Aetiology multifactorial• Loss of BMD observed with ART initiation• Greater loss of BMD with initiation of certain ARVs⁽ⁱ⁾	<p>Consider classic risk factors⁽ⁱⁱ⁾ and estimate fracture risk using FRAX.</p> <p>Consider DXA in any person with ≥ 1 risk of:⁽ⁱⁱⁱ⁾</p> <ol style="list-style-type: none">1. Postmenopausal women2. Men ≥ 50 years3. Those between 40-50 years with high fracture risk (> 20% 10-year major osteoporotic fracture risk based on FRAX assessment without DXA)4. History of low impact fracture5. High risk for falls^(iv)6. Clinical hypogonadism (symptomatic, see Sexual Dysfunction)7. Oral glucocorticoid use (minimum 5 mg/qd prednisone equivalent for > 3 months) <p>Preferably perform DXA in those with above risk factors prior to ART initiation. Assess effect of risk factors on fracture risk by including DXA results in the FRAX® score (http://www.shef.ac.uk/FRAX)</p> <ul style="list-style-type: none">• Only use if > 40 years• May underestimate risk in HIV-positive persons• Consider using HIV as a cause of secondary osteoporosis^(v)	<p>DXA scan</p> <p>Rule out causes of secondary osteoporosis if BMD low^(vi)</p> <p>Lateral spine X-rays (lumbar and thoracic) if low spine BMD, osteoporosis on DXA, or significant height loss or kyphosis develops. (DXA-based vertebral fracture assessment can be used as an alternative to lateral spine X-ray).</p>												
Osteomalacia	<ul style="list-style-type: none">• Defective bone mineralisation• Increased risk of fractures and bone pain• Vitamin D deficiency may cause proximal muscle weakness• High prevalence (> 80%) of vitamin D insufficiency in some HIV cohorts and in the general population	<ul style="list-style-type: none">• Dark skin• Dietary deficiency• Avoidance of sun exposure• Malabsorption• Obesity• Renal phosphate wasting^(vii)	<table><tr><td colspan="3">Measure 25(OH) vitamin D in all persons at presentation</td></tr><tr><td></td><td>ng/mL</td><td>nmol/L</td></tr><tr><td>Deficiency</td><td>< 10</td><td>< 25</td></tr><tr><td>Insufficiency</td><td>< 20</td><td>< 50</td></tr></table> <p>If deficient or insufficient, check PTH levels Consider vitamin D replacement if clinically indicated, see page 50</p>	Measure 25(OH) vitamin D in all persons at presentation				ng/mL	nmol/L	Deficiency	< 10	< 25	Insufficiency	< 20	< 50
Measure 25(OH) vitamin D in all persons at presentation															
	ng/mL	nmol/L													
Deficiency	< 10	< 25													
Insufficiency	< 20	< 50													
Osteonecrosis	<ul style="list-style-type: none">• Infarct of epiphyseal plate of long bones resulting in acute bone pain• Rare but increased prevalence in HIV	<p>Risk factors:</p> <ul style="list-style-type: none">• Low CD4 count• Glucocorticoid exposure• IVDU	<p>MRI</p>												

- i Greater loss of BMD observed with initiation of regimens containing TDF and some PIs. Additional loss and gains in BMD observed with switch to and away from TDF-containing ARV regimens, respectively. Clinical relevance to fracture risk not determined. TAF is associated with less bone loss than TDF.
Consider replacing TDF* by non-tenofovir drug or TAF** if:
- Osteoporosis / progressive bone loss
 - History of fragility fracture
 - FRAX score for major osteoporotic fracture $> 10\%$
 - Use of a PI/r as third agent
- * Expert opinion, pending clinical data
** There is limited data on use of TAF with eGFR ≤ 30 mL/min and longer term outcomes are unknown.
- ii Classic risk factors: older age, female gender, hypogonadism, family history of hip fracture, low BMI (≤ 19 kg/m²), vitamin D deficiency, smoking, physical inactivity, history of low trauma fracture, alcohol excess (> 3 units/day), glucocorticoid exposure (minimum prednisone 5 mg/qd or equivalent for > 3 months)
- iii If T-score normal, repeat after 3-5 years in risk groups 1, 2 and 5; no need for re-screening with DXA in risk groups 3 and 4 unless risk factors change and only rescreen group 6 if glucocorticoid use ongoing.
- iv Falls Risk Assessment Tool (FRAT), see <https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/healthy-ageing/falls-prevention/falls-prevention-tools>
- v If including BMD within FRAX, entering yes in the secondary cause box will not be considered in the FRAX algorithms, as it is assumed that secondary osteoporosis affects fracture risk solely through BMD. However, if the contribution of HIV infection to fracture risk is partially independent of BMD, fracture probability may be underestimated by FRAX.
- vi Causes of secondary osteoporosis include hyperparathyroidism, hyperthyroidism, malabsorption, hypogonadism/amenorrhoea, diabetes mellitus, and chronic liver disease.
- vii For diagnosis and management of renal phosphate wasting, see [Indications and Tests for Proximal Renal Tubulopathy \(PRT\)](#).

Vitamin D Deficiency: Diagnosis and Management

Vitamin D	Test	Therapy ⁽ⁱ⁾
Deficiency: < 10 ng/mL (< 25 nmol/L) ⁽ⁱⁱ⁾ Insufficiency: < 20 ng/mL (< 50 nmol/L)	Serum 25-hydroxy vitamin D (25(OH) vitamin D) If deficient, consider checking parathyroid hormone (PTH), calcium, phosphate ⁽ⁱⁱⁱ⁾ , alkaline phosphatase	If vitamin D deficient, replacement recommended. Various regimens suggested ^(iv) Consider re-checking 25(OH) vitamin D levels 3 months after replacement. After replacement, maintenance with 800-2,000 IU vitamin D daily.
Vitamin D deficiency prevalent in both HIV-positive and HIV-negative populations – may not be directly associated with HIV. Factors associated with lower vitamin D: <ul style="list-style-type: none"> • Dark skin • Dietary deficiency • Avoidance of sun exposure • Malabsorption • Obesity • Chronic kidney disease • Some ARVs^(v) 	Check vitamin D status in persons with history of: <ul style="list-style-type: none"> • low bone mineral density and/or fracture • high risk for fracture Consider assessment of vitamin D status in persons with other factors associated with lower vitamin D levels (see left column)	Replacement and/or supplementation of vitamin D is recommended for persons with both vitamin D insufficiency ^(vi) and one of the following: <ul style="list-style-type: none"> • osteoporosis • osteomalacia • increased PTH (once the cause has been identified) Consider re-testing after 6 months of vitamin D intake

- i Can be provided according to national recommendations/availability of preparations (oral and parenteral formulations). Combine with calcium where there is insufficient dietary calcium intake. Consider that in some countries food is artificially fortified with vitamin D.
- ii Some experts consider a value of ≤ 30 ng/mL as vitamin D deficiency. Low vitamin D has a prevalence of up to 80% in HIV cohorts and was associated with increased risk for osteoporosis, type 2 diabetes, mortality and AIDS events. Consider seasonal differences (in winter approximately 20% lower than in summer).
- iii Consider that hypophosphataemia can be associated with TDF therapy. This phosphate loss through proximal renal tubulopathy may be independent of low vitamin D, see page 54. A combination of low calcium + low phosphate +/- high alkaline phosphatase may indicate osteomalacia and vitamin D deficiency.
- iv Expect that 100 IU vitamin D daily leads to an increase in serum 25(OH) vitamin D of approximately 1 ng/mL. Some experts prefer a loading dose of e.g. 10,000 IU vitamin D daily for 8-10 weeks in persons with vitamin D deficiency. The principal goal is to achieve a serum level > 20 ng/mL (50 nmol/L) and to maintain normal serum PTH levels. Combine with calcium where potential for insufficient dietary calcium intake. The therapeutic aim is to maintain skeletal health; vitamin D supplementation has not been proven to prevent other co-morbidities in HIV-positive persons.
- v The role of HIV-therapy or specific drugs remains unclear. Some studies suggest an association of EFV with reductions in 25(OH)D but not 1.25(OH)D. PIs may also affect vitamin D status by inhibiting conversion of 25(OH)D to 1.25(OH)D.
- vi The implications of vitamin D levels that are below the physiological reference range but not markedly reduced and the value of supplementation are not completely understood.

Approach to Fracture Reduction in HIV-positive Persons

Reducing risk of fractures	<ul style="list-style-type: none"> • Aim to decrease falls by addressing fall risks⁽ⁱ⁾ • Ensure sufficient dietary calcium (1-1.2 g daily) and vitamin D (800-2,000 IU daily) intake⁽ⁱⁱ⁾ • Where appropriate, screen for osteoporosis⁽ⁱⁱⁱ⁾ and refer to national/regional guidelines on treatment of osteoporosis <ul style="list-style-type: none"> – If no guidelines available, consider bisphosphonate^(iv) treatment in all osteoporotic postmenopausal women and men > 50 years old (BMD T-score \leq -2.5) and those with a history of fragility fracture. Consider treatment based on BMD alongside consideration of other risk factors for fracture, especially age. – Use bisphosphonate and ensure adequate calcium and vitamin D intake – No significant interactions between bisphosphonates and antiretrovirals – If antiretroviral-naïve, consider options for ART that preserve BMD^(v) – If diagnosed with osteoporosis and requiring therapy, consider optimising ART to preserve or improve BMD • In complicated cases (e.g. young men, premenopausal women, recurrent fracture despite bone protective therapy), refer to osteoporosis specialist • If on bisphosphonate treatment, repeat DXA after 2 years and reassess need for continued treatment after 3-5 years 	<ul style="list-style-type: none"> i Falls Risk Assessment Tool (FRAT), see https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/healthy-ageing/falls-prevention/falls-prevention-tools ii See page 50 for diagnosis and management of vitamin D deficiency. iii See page 49 for screening and diagnosis of bone disease in HIV. iv Bisphosphonate treatment with either of: alendronate 70 mg once weekly po; risedronate 35 mg once weekly po; ibandronate 150 mg po once a month or 3 mg iv every 3 months; zoledronic acid 5 mg iv once yearly. v BMD loss is greatest in the first year after ART initiation, with more BMD loss with ART regimens containing TDF and some PIs. Consider relative risk/benefit of using these agents in persons with high fracture risk. Reduced BMD loss is seen in those with optimised vitamin D status.
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Kidney Disease: Definition, Diagnosis and Management

Diagnosis of kidney disease

		eGFR ⁽ⁱ⁾			
		> 60 mL/min	> 60 mL/min, but accelerated decline of eGFR*	> 30 - ≤ 60 mL/min	≤ 30 mL/min
Proteinuria ⁽ⁱⁱ⁾	UP/C ⁽ⁱⁱⁱ⁾ < 50	Regular follow-up	<ul style="list-style-type: none"> Check risk factors for CKD and nephrotoxic medicines including ART^(iv, x) Discontinue or adjust drug dosages where appropriate^(v) Perform renal ultrasound If haematuria present with any level of proteinuria refer to nephrologist Refer to nephrologist if new CKD or progressive decline in eGFR 		
	UP/C ⁽ⁱⁱⁱ⁾ 50-100				
	UP/C ⁽ⁱⁱⁱ⁾ > 100		<ul style="list-style-type: none"> Check risk factors for CKD and nephrotoxic medicines including ART^(iv) Discontinue or adjust drug dosages where appropriate^(v) Perform renal ultrasound Urgent referral to nephrologist 		

* Defined as decrease in eGFR of 5 mL/min per year for ≥3 consecutive years or confirmed 25% eGFR decline from baseline

Management of HIV-associated kidney disease^(vi)

Prevention of progressive renal disease	Comment
1. ART	<p>Start ART immediately where HIV-associated nephropathy (HIVAN)^(vii) or HIV immune complex disease strongly suspected. Immunosuppressive therapy may have a role in immune complex diseases. Renal biopsy to confirm histological diagnosis recommended</p> <p>Consider replacing TDF** by non-tenofovir drug or TAF*** if:</p> <ul style="list-style-type: none"> UP/C 20-50 mg/mmol eGFR > 60 mL/min, but decrease in eGFR by 5 mL/min per year for at least 3 consecutive years or confirmed 25% eGFR decline from baseline co-morbidities with a high risk of CKD (i.e. diabetes and hypertension) body weight < 60 kg use of a PI/r as a third agent <p>Replace TDF** by non-tenofovir drug or TAF*** if:</p> <ul style="list-style-type: none"> eGFR ≤ 60 mL/min UP/C > 50 mg/mmol nephrotoxic comedication previous TDF toxicity (proximal renal tubulopathy) <p>** Expert opinion pending clinical data</p> <p>*** There are limited data on use of TAF with eGFR ≤ 30 mL/min, and longer term outcomes are unknown.</p>
2. Start ACE inhibitors or angiotensin-II receptor antagonists if: a. Hypertension and/or b. Proteinuria	<p>Monitor eGFR and K⁺ level closely on starting treatment or increasing dose</p> <p>a. Blood pressure target: < 130/80 mmHg</p>
3. General measures: a. Avoid nephrotoxic drugs b. Lifestyle measures (smoking, weight, diet) c. Treat dyslipidaemia ^(viii) and diabetes ^(ix) d. Adjust drug dosages where necessary ^(v)	CKD and proteinuria are independent risk factors for CVD

- i For eGFR: Use CKD-EPI formula based on serum creatinine, gender, age and ethnicity because eGFR quantification is validated > 60 mL/min. The abbreviated modification of diet in renal disease (aMDRD) or the Cockcroft-Gault (CG) equation may be used as an alternative; see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>. Definition CKD: eGFR ≤ 60 mL/min for ≥ 3 months (see http://www.kdigo.org/clinical_practice_guidelines/pdf/CKD/KDIGO_2012_CKD_GL.pdf). If not previously known to have CKD, confirm pathological eGFR within 2 weeks. Use of DTG, COBI and RTV boosted PIs is associated with an increase in serum creatinine/reduction of eGFR due to inhibition of proximal tubular creatinine transporters without impairing actual glomerular filtration: consider new set point after 1-2 months
- ii Urinalysis: use urine dipstick to screen for haematuria. To screen for proteinuria, use urine dipstick and if ≥ 1+ check urine protein/creatinine (UP/C), or screen with UP/C. Proteinuria defined as persistent if confirmed on ≥ 2 occasions > 2-3 weeks apart. If UP/C not available, use urine albumin/creatinine (UA/C), see⁽ⁱⁱⁱ⁾
- iii UP/C in spot urine is preferred to UA/C as detects total urinary protein secondary to glomerular and tubular disease. UA/C largely detects glomerular disease and can be used for screening for HIV-associated renal disease where UP/C is not available, but is not appropriate for screening for tubular proteinuria secondary to drug nephrotoxicity (e.g. TDF). If both UP/C and UA/C are measured, UP/C > UA/C suggests tubular proteinuria. Screening values for UA/C are: < 30, 30-70 and > 70. UA/C should be monitored in persons with diabetes. UPC ratio is calculated as urine protein (mg/L) / urine creatinine (mmol/L); may also be expressed as mg/mg. Conversion factor for mg to mmol creatinine is x 0.000884
- iv Repeat eGFR and urinalysis as per screening table, see page 7
- v See [Dose Adjustment of ARVs for Impaired Renal Function](#)
- vi Joint management with a nephrologist
- vii HIVAN suspected if black ethnicity & UP/C > 100 mg/mmol & no haematuria
- viii See page 48
- ix See page 46-47
- x Different models have been developed for calculating a 5-years CKD risk score while using different nephrotoxic ARVs integrating HIV-independent and HIV-related risk factors [6], [7]

See online video lecture [CVD, CKD and Endocrinology](#) from the EACS online course Clinical Management of HIV.

ARV-associated Nephrotoxicity

Renal abnormality*	ARV	Management
Proximal tubulopathy with any combination of: <ol style="list-style-type: none"> 1. Proteinuria: urine dipstick ≥ 1, or confirmed increase in UP/C > 30 mg/mmol⁽ⁱ⁾ 2. Progressive decline in eGFR and eGFR ≤ 90 mL/min⁽ⁱⁱ⁾ 3. Phosphaturia⁽ⁱⁱⁱ⁾: confirmed hypophosphataemia secondary to increased urine phosphate leak 4. Glucosuria in non-diabetics 	TDF**	Assessment: <ul style="list-style-type: none"> • Tests for proximal renal tubulopathy/renal Fanconi syndrome⁽ⁱⁱⁱ⁾ • Consider renal bone disease if hypophosphataemia of renal origin: measure 25(OH) vitamin D, PTH, DXA Replace TDF by non-tenofovir drug or TAF*** if: <ul style="list-style-type: none"> • Documented tubular proteinuria and/or glucosuria • Progressive decline in eGFR and no other cause • Confirmed hypophosphataemia of renal origin and no other cause • Osteopenia/osteoporosis in the presence of increased urine phosphate leak
Nephrolithiasis: <ol style="list-style-type: none"> 1. Crystalluria 2. Haematuria^(iv) 3. Leukocyturia 4. Loin pain 5. Acute renal insufficiency 	IDV ATV (DRV)	Assessment: <ul style="list-style-type: none"> • Urinalysis for crystalluria/stone analysis • Exclude other cause for nephrolithiasis • Renal tract imaging including CT scan Consider stopping IDV/ATV if: <ul style="list-style-type: none"> • Confirmed renal stones • Recurrent loin pain +/- haematuria
Interstitial nephritis: <ol style="list-style-type: none"> 1. Progressive decline in eGFR⁽ⁱⁱ⁾ 2. Tubular proteinuria⁽ⁱⁱⁱ⁾/ haematuria 3. Eosinophiluria (if acute) 4. Leukocyte casts 	IDV ATV	Assessment: <ul style="list-style-type: none"> • Renal ultrasound • Refer to nephrologist Consider stopping IDV/ATV if: <ul style="list-style-type: none"> • Progressive decline in eGFR and no other cause
Progressive decline in eGFR, but none of the above^(v)	TDF** PI/r	Complete assessment: <ul style="list-style-type: none"> • Risk factors for CKD^(v) (see Kidney Disease: Definition, Diagnosis and Management) • PRT, UA/C, UP/C (see Kidney Disease: Definition, Diagnosis and Management and Indications and Tests for Proximal Renal Tubulopathy (PRT)) • Renal tract ultrasound Consider stopping ARVs with potential nephrotoxicity if: <ul style="list-style-type: none"> • Progressive decline in eGFR and no other cause^(v)

* Use of COBI, DTG, RPV, but also PI/r is associated with an increase in serum creatinine/reduction of eGFR due to inhibition of proximal tubular creatinine transporters without impairing actual glomerular filtration: consider new set point after 1-2 months

** TAF has shown lower tenofovir-related renal adverse effects due to lower systemic tenofovir exposure. Switch-studies from TDF to TAF and certain PIs suggest potential reversion of renal toxicity, however, long-term experience with TAF is lacking

*** Particularly if eGFR > 30 mL/min, as there are limited data to on use of TAF with eGFR ≤ 30 mL/min, and longer term outcomes are unknown

i UP/C in spot urine detects total urinary protein including protein of glomerular or tubular origin. The urine dipstick analysis primarily detects albuminuria as a marker of glomerular disease and is inadequate to detect tubular disease.

ii For eGFR: use CKD-EPI formula based on serum creatinine, gender, age and ethnicity because eGFR quantification is validated > 60 mL/min. The abbreviated modification of diet in renal disease (aMDRD) or the Cockcroft-Gault (CG) equation may be used as an alternative; see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>.

iii See [Indications and Tests for Proximal Renal Tubulopathy \(PRT\)](#)

iv Microscopic haematuria is usually present.

v Different models have been developed for calculating a 5-years CKD risk score while using different nephrotoxic ARVs integrating HIV-independent and HIV-related risk factors [6], [7].

Indications and Tests for Proximal Renal Tubulopathy (PRT)

Indications for proximal renal tubulopathy tests	Proximal renal tubulopathy tests ^(iv) , including	Replace TDF by non-tenofovir drug or TAF* alternative drug if:
<ul style="list-style-type: none"> Progressive decline in eGFR⁽ⁱ⁾ & eGFR ≤ 90 mL/min & no other cause and/or Confirmed hypophosphataemia⁽ⁱⁱ⁾ and/or Confirmed increase in UP/C⁽ⁱⁱⁱ⁾ Renal insufficiency even if stable (eGFR ≤ 60 mL/min) Tubular proteinuria^(v) 	<ul style="list-style-type: none"> Blood phosphate and urinary phosphate excretion^(vi) Blood glucose and glucosuria Serum bicarbonate and urinary pH^(vii) Blood uric acid level and urinary uric acid excretion^(viii) Serum potassium and urinary potassium excretion 	<ul style="list-style-type: none"> Confirmed proximal renal tubulopathy with no other cause

- i** For eGFR: use CKD-EPI formula. The abbreviated MDRD (Modification of Diet in Renal Disease) or the Cockcroft-Gault (CG) equation may be used as an alternative, see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>.
- ii** Serum phosphate < 0.8 mmol/L or according to local thresholds; consider renal bone disease, particularly if alkaline phosphatase increased from baseline: measure 25(OH) vitamin D, PTH.
- iii** UP/C in spot urine, detects total urinary protein, including protein of glomerular or tubular origin. The urine dipstick analysis primarily detects albuminuria as a marker of glomerular disease and is inadequate to detect tubular disease.
- iv** It is uncertain which tests discriminate best for TDF renal toxicity. Proximal tubulopathy is characterised by: proteinuria, hypophosphataemia, hypokalaemia, hypouricaemia, renal acidosis, glucosuria with normal blood glucose level. Renal insufficiency and polyuria may be associated. Most often, only some of these abnormalities are observed.
- v** Tests for tubular proteinuria include retinol binding protein, α1- or β2-microglobulinuria, urine cystatin C, aminoaciduria.
- vi** Quantified as fractional excretion of phosphate (FEPHos): $(\text{PO}_4(\text{urine}) / \text{PO}_4(\text{serum})) / (\text{Creatinine}(\text{urine}) / \text{Creatinine}(\text{serum}))$ in a spot urine sample collected in the morning in fasting state. Abnormal > 0.2 (> 0.1 with serum phosphate < 0.8 mmol/L).
- vii** S-bicarbonate < 21 mmol/L and urinary pH > 5.5 suggests renal tubular acidosis.
- viii** Fractional excretion of uric acid (FEUricAcid): $(\text{UricAcid}(\text{urine}) / \text{UricAcid}(\text{serum})) / (\text{Creatinine}(\text{urine}) / \text{Creatinine}(\text{serum}))$ in a spot urine sample collected in the morning in fasting state; abnormal > 0.1.
- *** Particularly if eGFR > 30 mL/min, as there are limited data on use of TAF with eGFR ≤ 30 mL/min.

Dose Adjustment of ARVs for Impaired Renal Function

eGFR ⁽ⁱ⁾ (mL/min)						Haemodialysis
		≥ 50	30-49	10-29	< 10	
NRTIs						
ABC		300 mg q12h	No dose adjustment required			
ddl ⁽ⁱⁱ⁾	≥ 60 kg	400 mg q24h	200 mg q24h	150 mg q24h	100 mg q24h	100 mg q24h ^(iv)
	< 60 kg	250 mg q24h	125 mg q24h	100 mg q24h	75 mg q24h	75 mg q24h ^(iv)
d4T	≥ 60 kg	40 mg q12h	20 mg q12h	20 mg q24h	20 mg q24h	20 mg q24h ^(iv)
	< 60 kg	30 mg q12h	15 mg q12h	15 mg q24h	15 mg q24h	15 mg q24h ^(iv)
FTC		200 mg q24h	200 mg q48h	200 mg q72h	200 mg q96h	200 mg q96h ^(iv)
3TC		300 mg q24h	150 mg q24h	100 mg q24h ⁽ⁱⁱⁱ⁾	50-25 mg q24h ⁽ⁱⁱⁱ⁾	50-25 mg q24h ^{(iii), (iv)}
TDF ^(v)		300 ^(viii) mg q24h	300 ^(viii) mg q48h	Not recommended	Not recommended	300 ^(viii) mg q7d ^(iv)
				(300 ^(viii) mg q72-96h, if no alternative)	(300 ^(viii) mg q7d, if no alternative)	
ZDV		300 mg q12h	No dose adjustment required		100 mg q8h	100 mg q8h ^(iv)
ABC/3TC		600/300 mg q24h	Use individual drugs			
ZDV/3TC		300/150 mg q12h				
ABC/3TC/ZDV		300/150/300 mg q12h				
TAF/FTC		25 ^(ix) /200 mg q24h			Not recommended	
TDF/FTC		300 ^(viii) /200 mg q24h	300 ^(viii) /200 mg q48h	Use individual drugs		
NNRTIs						
EFV		600 mg q24h	No dose adjustment required			
ETV		200 mg q12h	No dose adjustment required			
NVP		200 mg q12h	No dose adjustment required			
TAF/FTC/RPV		25/200/25 mg q24h			Not recommended	
TDF/FTC/RPV		300 ^(viii) /200/25 mg q24h	Do not use			

eGFR ⁽ⁱ⁾ (mL/min)					Haemodialysis
	≥ 50	30-49	10-29	< 10	
PIs ^(v)					
ATV/c	300/150 mg q24h	No dose adjustment required ^(vi)			
ATV/r	300/100 mg q24h	No dose adjustment required ^(vi)			
DRV/r	800/100 mg q24h 600/100 mg q12h	No dose adjustment required ^(vi)			
DRV/c	800/150 mg q24h	No dose adjustment required ^(vi)			
TAF/FTC/DRV/c	10/200/800/150 mg q24h	Not recommended			
FPV/r	700/100 mg q12h	No dose adjustment required ^(vi)			
LPV/r	400/100 mg q12h	No dose adjustment required ^(vi)			
SQV/r	1000/100 mg q12h	No dose adjustment required ^(vi)			
TPV/r	500/200 mg q12h	No dose adjustment required ^(vi)			
Other ART					
RAL	1 x 400 mg tablet q12h or 2 x 600 mg tablets q24h	No dose adjustment required ^(vi)			
DTG	50 mg q24h	No dose adjustment required ^(vi)			No clinical data; PK data suggest safety
ABC/3TC/DTG	600/300/50 mg q24h	Use individual drugs			
TAF/FTC/BIC	20/200/75 mg q24h	Not recommended			
TAF/FTC/EVG/c	10/200/150/150 mg q24h		Not recommended		
TDF/FTC/EVG/c	Do not initiate if eGFR < 70 mL/min	Do not use			
MVC: co-administered without CYP3A4 inhibitors ^(vii)	300 mg q12h	No dose adjustment required ^(vi)			
MVC: co-administered with CYP3A4 inhibitors ^(vii)	If eGFR < 80 mL/min 150 mg q24h ^(vii) except: 150 mg q12h if co-administered with FPV/r				

i eGFR: Use CKD-EPI formula; the abbreviated modification of diet in renal disease (aMDRD) or the Cockcroft-Gault (CG) equation may be used as an alternative; see <https://www.chip.dk/Tools-Standards/Clinical-risk-scores>

ii Dose reduction if combined with TDF

iii 150 mg loading dose

iv After dialysis

v TDF and (boosted) PIs are associated with nephrotoxicity; consider alternative ART if pre-existing CKD, risk factors for CKD and/or decreasing eGFR, see [ARV-associated Nephrotoxicity and Kidney Disease: Definition, Diagnosis and Management](#)

vi Limited data available in persons with renal impairment; pharmacokinetic analysis suggests no dose adjustment required

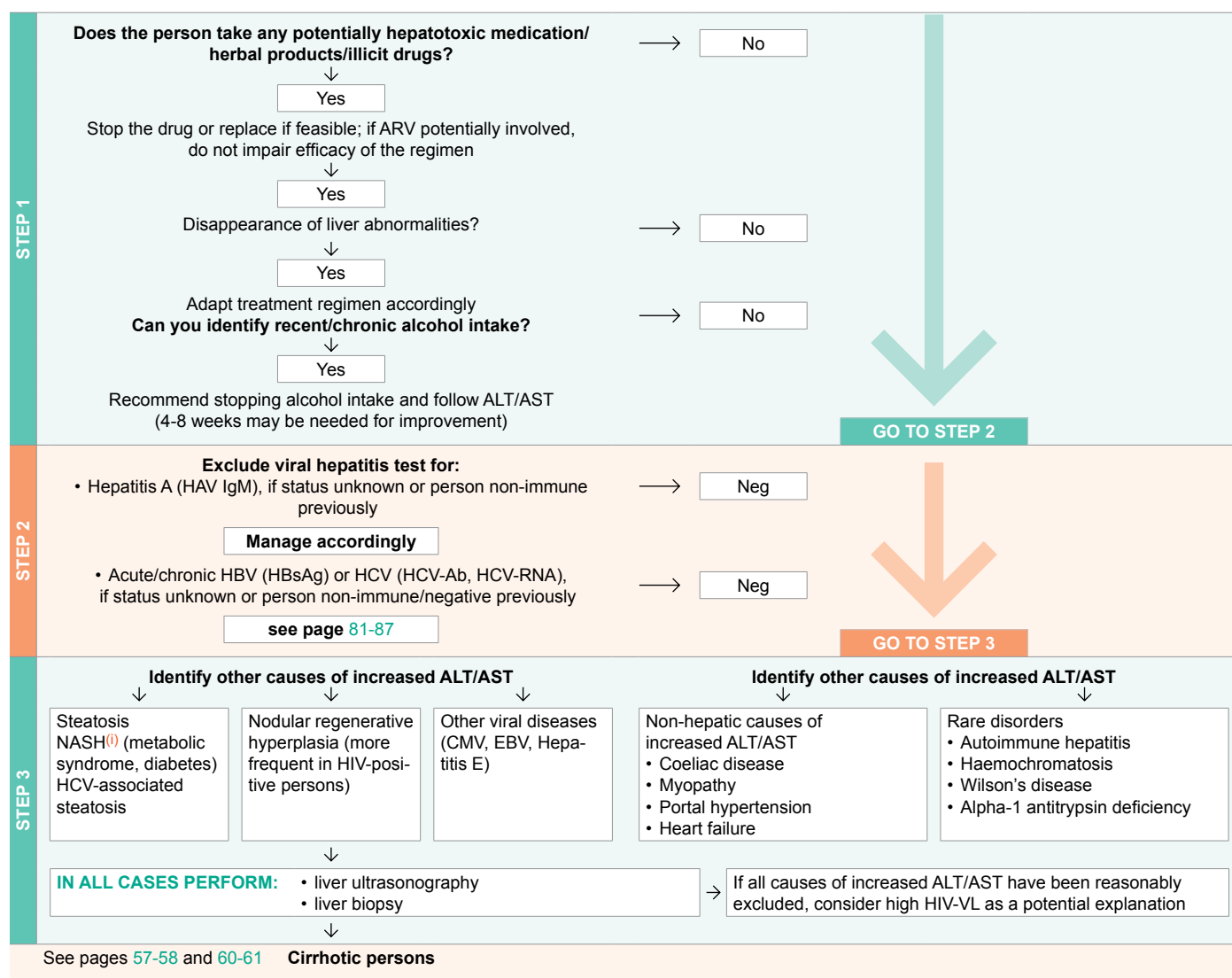
vii See summary of product characteristics for specific recommendations; use with caution if eGFR ≤ 30 mL/min

viii In certain countries TDF is labelled as 245 mg rather than 300 mg to reflect the amount of the prodrug (tenofovir disoproxil) rather than the fumarate salt (tenofovir disoproxil fumarate)

ix 10 mg if co-administered with a boosting agent (inhibition of P-glycoprotein, P-gp)

Work-up and Management of HIV-positive Persons with Increased ALT/AST

Identify potential cause of increased liver enzymes, using the following steps:



ⁱ Non-Alcoholic SteatoHepatitis, see [NAFLD](#)

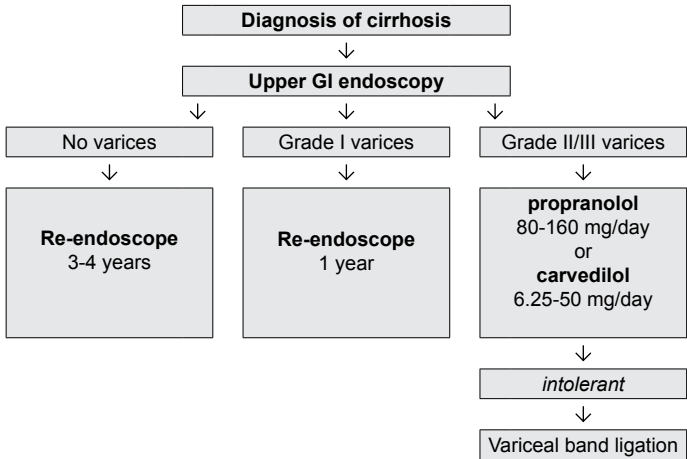
Liver Cirrhosis: Classification and Surveillance

Child-Pugh classification of the severity of cirrhosis

	Points ⁽¹⁾		
	1	2	3
Total bilirubin, mg/dL (μmol/L)	< 2 (< 34)	2-3 (34-50)	> 3 (> 50)
Serum albumin, g/L (μmol/L)	> 35 (> 507)	28-35 (406-507)	< 28 (< 406)
INR	< 1.7	1.7-2.20	> 2.20
Ascites	None	Mild/Moderate (diuretic responsive)	Severe (diuretic refractory)
Hepatic encephalopathy	None	Grade I-II (or suppressed with medicine)	Grade III-IV (or refractory)

- 5-6 points: Class A
- 7-9 points: Class B
- 10-15 points: Class C

Algorithm for surveillance for varices and primary prophylaxis



Liver Cirrhosis: Management

Management of HIV-positive persons with cirrhosis should be done in collaboration with experts in liver diseases. More general management guidance is described below.

For dosage adjustment of antiretrovirals, see [Dose Adjustment of ARVs for Impaired Hepatic Function](#).

In end-stage liver disease (ESLD), use of EFV may increase risk of CNS symptoms.

ART, if otherwise indicated, also provides net benefit to cirrhotic persons.

See [Diagnosis and Management of Hepatorenal Syndrome \(HRS\)](#).

Management of hypervolaemic hyponatraemia	Management strategy of hepatic encephalopathy (HE)
<ol style="list-style-type: none"> Fluid restriction: 1000-1500 mL/day (consumption of bouillon allowed ad libitum) If fluid restriction is ineffective, consider use of oral tolvaptan <ol style="list-style-type: none"> To be started in hospital at 15 mg/day for 3-5 days, then titrated to 30-60 mg/day until normal s-Na; duration of treatment unknown (efficacy/safety only established in short-term studies (1 month)) S-Na should be monitored closely, particularly after initiation, dose modification or if clinical status changes Rapid increases in s-Na concentration (> 8 mmol/day) should be avoided to prevent osmotic demyelination syndrome Persons may be discharged after s-Na levels are stable and without need to further adjust dose 	<p>General management</p> <ol style="list-style-type: none"> Identify and treat precipitating factor (GI haemorrhage, infection, pre-renal azotaemia, constipation, sedatives) Short-term (< 72 hours) protein restriction may be considered if HE is severe <p>Specific therapy</p> <p>Lactulose 30 cm³ po every 1-2h until bowel evacuation, then adjust to a dosage resulting in 2-3 formed bowel movements per day (usually 15-30 cm³ po bid)</p> <p>Lactulose enemas (300 cm³ in 1L of water) in persons who are unable to take it po. Lactulose can be discontinued once the precipitating factor has resolved</p>

Management strategy in uncomplicated ascites	
General management	<ul style="list-style-type: none"> Treat ascites once other complications have been treated Avoid NSAIDs Norfloxacin prophylaxis (400 mg po, qd) in persons with <ol style="list-style-type: none"> an ascites protein level of < 1.5 mg/dL, impaired renal function (serum creatinine level > 1.2 mg/dL, BUN > 25 mg/dL), s-Na level < 130mEq/L), or severe liver failure (Child-Pugh score > 9 points with s-bilirubin level > 3 mg/dL)
Specific management	<ul style="list-style-type: none"> Salt restriction: 1-2 g/day. Liberalise if restriction results in poor food intake Large volume paracentesis as initial therapy only in persons with tense ascites Administer iv albumin (= 6-8 g/L ascites removed)
Follow-up and goals	<ul style="list-style-type: none"> Adjust diuretic dosage every 4-7 days Weigh the person at least weekly and BUN, s-creatinine, and electrolytes measured every 1-2 weeks while adjusting dosage Double dosage of diuretics if: weight loss < 2 kg a week and BUN, creatinine and electrolytes are stable Halve the dosage of diuretics or discontinue if: weight loss ≥ 0.5 kg/day or if there are abnormalities in BUN, creatinine or electrolytes Maximum diuretic dosage: spironolactone (400 mg qd) and furosemide (160 mg qd)

Nutrition of cirrhotic persons	
<p>Caloric requirements</p> <ul style="list-style-type: none"> 25-30 Kcal/kg/day of normal body weight <p>Protein requirements</p> <ul style="list-style-type: none"> Protein restriction is not recommended (see above for exception if HE) 	<ul style="list-style-type: none"> Type: rich in branched chain (non-aromatic) amino acids Some studies support that parenteral proteins carry less risk of encephalopathy since not converted by colonic bacteria into NH₃ <p>Micronutrients</p> <ul style="list-style-type: none"> Mg and Zn

Analgesia in persons with hepatic failure	
<ul style="list-style-type: none"> Acetaminophen can be used; caution on daily dose (max 2 g/day). NSAIDs generally avoided; predispose persons with cirrhosis to develop GI bleeding. Persons with decompensated cirrhosis are at risk for NSAID-induced renal insufficiency. 	<ul style="list-style-type: none"> Opiate analgesics are not contraindicated but must be used with caution in persons with pre-existing hepatic encephalopathy.

Screening for HepatoCellular Carcinoma (HCC)	
<ul style="list-style-type: none"> HCC screening is indicated in all cirrhotic HBV or HCV co-infected persons (even if HCV infection has been cured and HBV replication is medically suppressed) in a setting where treatment for HCC is available. Although the cost-effectiveness of HCC screening in persons with F3 fibrosis is uncertain, surveillance may be considered based on an individual risk assessment (http://www.easl.eu/research/our-contributions/clinical-practice-guidelines/detail/easl-clinical-practice-guidelines-on-hepatocellular-carcinoma). In HBV-positive non-cirrhotics, HCC screening should follow current EASL guidelines. Risk factors for HCC in this population include family history of HCC, ethnicity (Asians, Africans), HDV and age. EASL guidelines propose using the PAGE-B score in Caucasians to assess the HCC risk, however this score has not been validated in HIV-positive persons. F4 diagnosis made by transient elastography measurement should be validated by a biomarker score, signs of cirrhosis in liver in sonography or at least repetition of transient elastography after 6 months. F3 diagnosis made by transient elastography measurement should be confirmed by a second measurement after 6 months. Cut-offs for F4 (cirrhosis): 13.0 kPa, for F3: 10.0 kPa (http://www.easl.eu/research/our-contributions/clinical-practice-guidelines/detail/easl-recommendations-on-treatment-of-hepatitis-c-2018). Ultrasound (US) every 6 months. Alpha-fetoprotein is a suboptimal surveillance tool because of low sensitivity and specificity. 	

When to refer for liver transplantation	
<p>Best to refer early as disease progresses rapidly</p> <p>= MELD⁽ⁱ⁾ score 10-12 (listing at 15)</p> <p>Decompensated cirrhosis (at least one of the following complications)</p> <ul style="list-style-type: none"> Ascites Hepatic encephalopathy Variceal bleeding Spontaneous bacterial peritonitis Hepatorenal syndrome Hepatopulmonary syndrome HCC <p>See Solid Organ Transplantation (SOT) in HIV-positive Persons</p>	

ⁱ Unit for both S-creatinine and S-bilirubin is mg/dL.
MELD score = 10 {0.957 Ln (serum creatinine (mg/dL)) + 0.378 Ln (total bilirubin (mg/dL)) + 1.12 Ln (INR) + 0.643}, see <http://www.mdcalc.com/meld-score-model-for-end-stage-liver-disease-12-and-older/>

Non-Alcoholic Fatty Liver Disease (NAFLD)

The prevalence of NAFLD is higher in individuals with HIV infection (30–40% in the US) than in the general population [9]. Nearly half of the HIV-positive persons that undergo evaluation for unexplained liver test abnormalities are found to have NAFLD. The diagnosis of NAFLD requires the exclusion of both secondary causes and of a daily alcohol consumption ≥ 30 g for men and ≥ 20 g for women.

Spectrum of NAFLD

Often associated with components of the metabolic syndrome:

Non-Alcoholic Fatty Liver (NAFL)

- Pure steatosis

NAFLD

- Steatosis and mild lobular inflammation

Non-Alcoholic SteatoHepatitis (NASH)

- Early NASH: no or mild (F0–F1) fibrosis
- Fibrotic NASH: significant (\geq F2) or advanced (\geq F3, bridging) fibrosis
- NASH-cirrhosis (F4)
- HCC (can occur in the absence of cirrhosis and histological evidence of NASH)

Most common concurrent diseases

- AFLD-alcoholic fatty liver disease
- Drug-induced fatty liver disease
- HCV-associated fatty liver (GT 3)

Consideration on ARV drugs

- d-drugs (ddi, d4T) are contraindicated in individuals at risk of or with NAFLD
- Consider use of lipid neutral regimens in individuals at risk of or with NAFLD

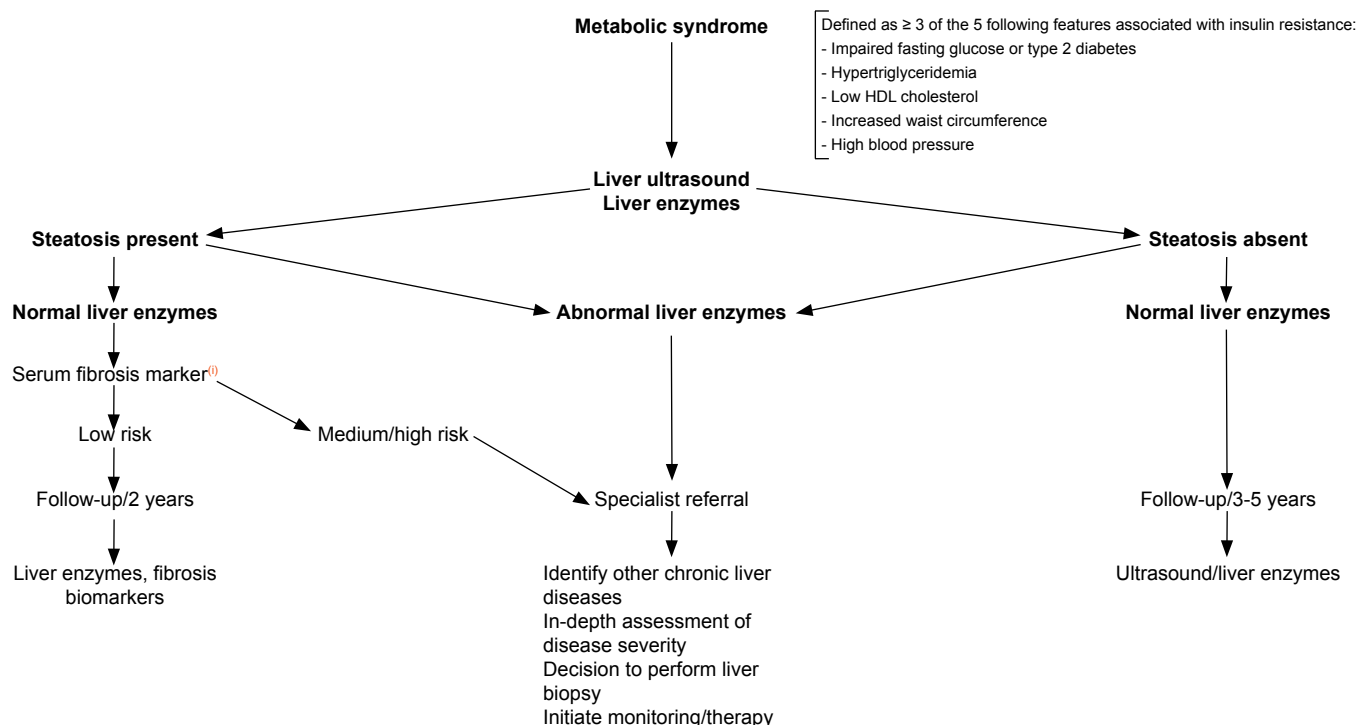
Diagnosis

- Ultrasound is the preferred first-line diagnostic procedure for imaging of NAFLD.
- Whenever imaging tools are not available or feasible, serum biomarkers and scores are an acceptable alternative for the diagnosis. Fibroscan is not validated for this purpose.
- A quantitative estimation of liver fat can only be obtained by ¹H-MRS. This technique is of value in clinical trials and experimental studies, but is expensive and not recommended in the clinical setting.
- NASH has to be diagnosed by a liver biopsy showing steatosis, hepatocyte ballooning and lobular inflammation.

Treatment of NAFLD

- Lifestyle modification and weight reduction is the cornerstone of treatment
- Pharmacotherapy should be reserved for individuals with NASH, particularly for those with significant fibrosis \geq F2 and individuals with less severe disease, but at high risk of faster disease progression (i.e. with diabetes, metabolic syndrome, persistently increased ALT, high necroinflammation).
- Management and treatment of NASH should be discussed with hepatologists. Options with proven efficacy include pioglitazone, vitamin E and bariatric surgery.
- Statins may be safely used but have demonstrated no impact on liver disease. The same is true for n-3 polyunsaturated fatty acids.

Diagnostic flow-chart to assess and monitor disease severity in case of suspected NAFLD and metabolic risk factors



ⁱ Serum fibrosis markers: NAFLD-Fibrosis Score, FIB-4, Commercial tests (FibroTest, FibroMeter, ELF)

These recommendations are largely inspired by the EASL–EASD–EASO Clinical Practice Guidelines for the Management of Non-Alcoholic Fatty Liver Disease: European Association for the Study of the Liver (EASL), European Association for the Study of Diabetes (EASD) and European Association for the Study of Obesity (EASO) [8].

Diagnosis and Management of Hepatorenal Syndrome (HRS)

Diagnosis	<p>Consider HRS in a person with cirrhosis and ascites and a creatinine level of > 1.5 mg/dL. It is a diagnosis of exclusion. Before making the diagnosis, the following need to be ruled out and treated:</p> <ul style="list-style-type: none"> • Sepsis (person needs to be pancultured) • Volume depletion (haemorrhage, diarrhoea, overdiuresis) • Vasodilators • Organic renal failure (urine sediment; kidney ultrasound) <p>Diuretics should be discontinued and intravascular volume expanded with iv albumin. If renal dysfunction persists despite above, diagnose HRS.</p>		
Recommended therapy	<p>Liver transplant (priority dependent on MELD score, see page 58). If person is on transplant list, MELD score should be updated daily and communicated to transplant centre, see Solid Organ Transplantation (SOT) in HIV-positive Persons.</p>		
Alternative (bridging therapy)	Vasoconstrictors	octreotide	100-200 µg sc tid → Goal to increase mean arterial pressure by 15 mmHg
		+ midodrine	5-15 mg po tid
		or terlipressin	0.5-2.0 mg iv every 4-6 hours
	and iv albumin (both for at least 7 days)		50-100 g iv qd

Dose Adjustment of ARVs for Impaired Hepatic Function

NRTIs	
ABC	Child-Pugh Class A: 200 mg bid (use oral solution) Child-Pugh Class B or C: contraindicated
ddl	Contraindicated If used no dosage adjustment
d4T	Contraindicated If used no dosage adjustment
FTC	No dosage adjustment
3TC	No dosage adjustment
TAF	No dosage adjustment
TAF/FTC	No dosage adjustment
TDF	No dosage adjustment
TDF/FTC	No dosage adjustment
ZDV	Reduce dose by 50% or double the interval between doses if Child-Pugh Class C
NNRTIs	
EFV	No dosage adjustment; use with caution in persons with hepatic impairment
TDF/FTC/EFV	
ETV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
NVP	Child-Pugh Class B or C: contraindicated
RPV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TAF/FTC/RPV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TDF/FTC/RPV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data

PIs	
ATV	Child-Pugh Class A: no dose adjustment Child-Pugh Class B: 300 mg qd (unboosted) Child-Pugh Class C: not recommended
ATV/c	Child-Pugh Class A: no dosage adjustment Child-Pugh Class B or C: not recommended
COBI	Refer to recommendations for the primary PI
DRV	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: not recommended
DRV/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: not recommended
TAF/FTC/DRV/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: not recommended
FPV	PI-naïve persons: Child-Pugh Class A or B: 700 mg bid Child-Pugh Class C: 350 mg bid PI-experienced persons: Child-Pugh Class A: 700 mg bid + RTV 100 mg qd Child-Pugh Class B: 450 mg bid + RTV 100 mg qd Child-Pugh Class C: 300 mg bid + RTV 100 mg qd
IDV	Child-Pugh Class A or B: 600 mg q8h Child-Pugh Class C: no data
LPV/r	No dosage recommendation; use with caution in persons with hepatic impairment
RTV	Refer to recommendations for the primary PI
SQV	Child-Pugh Class A or B: use with caution Child-Pugh Class C: contraindicated
TPV	Child-Pugh Class A: use with caution Child-Pugh Class B or C: contraindicated
FI	
ENF	No dosage adjustment
CCR5 Inhibitor	
MVC	No dosage recommendations. Concentrations will likely be increased in persons with hepatic impairment
INSTI	
RAL	No dosage adjustment
EVG	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
DTG	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TAF/FTC/EVG/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
TDF/FTC/EVG/c	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data
ABC/3TC/DTG	Use separate compounds and refer to those adjustments
TAF/FTC/BIC	Child-Pugh Class A or B: no dosage adjustment Child-Pugh Class C: no data

Note: Hepatic dysfunction is a good indication for TDM as clinical experience with these dose adjustments is very limited.

Lipodystrophy: Prevention and Management

Lipoatrophy	Lipohypertrophy ⁽ⁱ⁾
Prevention <ul style="list-style-type: none"> • Avoid d4T and ZDV or pre-emptively switch away from them. No evidence of benefit by switching other antiretrovirals. • Avoid excessive weight loss due to diet and exercise. • In ART-naïve persons, limb fat usually increases with initiation of ART not containing d4T or ZDV, reflecting “return-to-health” type of response. 	Prevention <ul style="list-style-type: none"> • No proven strategy • No current antiretroviral drug has been specifically associated with increased visceral adiposity • An excess of visceral fat has been reported in HIV vs. non-HIV non-obese persons for the same body mass index • Weight reduction or avoidance of weight gain may decrease visceral fat • Avoid corticosteroids with RTV or COBI-boosted drugs as it may cause Cushing syndrome or adrenal insufficiency (see Drug-Drug Interactions between Corticosteroids and ARVs)
Management <ul style="list-style-type: none"> • Modification of ART: Switch away from d4T or ZDV <ul style="list-style-type: none"> — Increase in total limb fat ~400-500 g/year (in the first two years) — Risk of toxicity from new drug, see Adverse Effects of ARVs & Drug Classes • Surgical intervention <ul style="list-style-type: none"> — Offered for cosmetic relief of (facial) lipoatrophy only 	Management <ul style="list-style-type: none"> • Diet and exercise may reduce visceral adiposity; <ul style="list-style-type: none"> — Limited data, but not consistently associated with improvement in insulin sensitivity and blood lipids — No prospective trials in HIV-positive persons to definitely indicate degree of diet and/or exercise needed to maintain reduction in visceral fat • Pharmacological interventions to treat lipohypertrophy have not been proven to provide long-term effects and may introduce new complications; • Growth hormone (not approved for this indication in Europe) <ul style="list-style-type: none"> — Decreases visceral adipose tissue — May worsen insulin resistance • Tesamorelin (not approved in Europe; approved for this indication by FDA)⁽ⁱⁱ⁾ • Metformin (not approved for this indication in Europe) <ul style="list-style-type: none"> — Decreases visceral adipose tissue in insulin resistant persons — May worsen subcutaneous lipoatrophy • Surgical therapy can be considered for localised lipomas/buffalo humps <ul style="list-style-type: none"> — Duration of effect variable

ⁱ Lipohypertrophy may occur as localised lipomas in the subcutaneous region or as increased visceral adiposity, both intraabdominally and/or in the epicardium.

ⁱⁱ Tesamorelin (growth hormone releasing factor) was shown to reduce visceral adipose tissue volume but this effect was lost on discontinuation.

See online video lecture [CVD, CKD and Endocrinology](#) from the EACS online course Clinical Management of HIV.

Hyperlactataemia and Lactic Acidosis: Diagnosis, Prevention and Management

Risk factors	Prevention/Diagnosis	Symptoms
<ul style="list-style-type: none"> • Use of ddI > d4T > ZDV • HCV/HBV co-infection • Use of ribavirin • Liver disease • Low CD4 count • Pregnancy • Female sex • Obesity 	<ul style="list-style-type: none"> • Avoid d4T + ddI combination • Routine monitoring of serum lactate levels not recommended - does not predict risk of lactic acidosis • Measurement of serum lactate, bicarbonate & arterial blood gases + pH indicated in case of symptoms suggestive of hyperlactataemia • Close monitoring for symptoms if > 1 risk factor 	<ul style="list-style-type: none"> • Hyperlactataemia: unexplained nausea, abdominal pain, hepatomegaly, elevated ALT and/or AST, weight loss • Acidaemia: asthenia, dyspnoea, arrhythmias • Guillain-Barré-like syndrome

Management

Serum lactate (mmol/L)	Symptoms	Action
> 5 ⁽ⁱ⁾	Yes/No	<ul style="list-style-type: none"> • Repeat test under standardised conditions to confirm & obtain arterial pH and bicarbonate⁽ⁱ⁾ • If confirmed, exclude other causes <ul style="list-style-type: none"> – Arterial pH ↓ and/or bicarbonate ↓⁽ⁱ⁾: Stop NRTIs – Arterial pH and/or bicarbonate normal: Consider switch from high to low-risk NRTI & monitor carefully OR stop NRTIs
2-5	Yes	Exclude other causes; if none found: watchfully follow up OR consider switch from high to low-risk NRTI, OR stop NRTI
2-5	No	Repeat test If confirmed, watchfully follow up
< 2		None

ⁱ Lactic acidosis is a rare but life-threatening situation usually associated with symptoms; high risk if serum lactate > 5 and especially > 10 mmol/L.

Management of lactic acidosis (irrespective of serum-lactate level)

Admit the person. Stop NRTIs. Provide iv fluids. Vitamin supplementation can be used (vitamin B complex forte 4 mL bid, riboflavin 20 mg bid, thiamine 100 mg bid; L-carnitine 1000 mg bid), although benefit is not proven.

Travel

General precautions	<ul style="list-style-type: none"> • Delay travel until clinically stable and treatment established • Provide drug prescription and referral letter for emergencies • Provide medical certificate for import of personal medicines/syringes • Carry antiretrovirals split between suitcase and hand luggage • Beware of fake drugs
ART	<ul style="list-style-type: none"> • Maintain hours of medicines (e.g. 23.00 local time) when switching time zones, shortening the interval to the next dose when flying east
Acknowledge increased susceptibility⁽ⁱ⁾ of HIV-positive	<p>1. Observe food hygiene</p> <ul style="list-style-type: none"> • Bacterial enterocolitis e.g. diarrhoeagenic <i>E. coli</i>, <i>Salmonella</i>, <i>Shigella</i>, <i>Campylobacter</i> • Opportunistic intestinal parasitosis Cryptosporidium, Cyclospora, Cystoisospora, Microsporidia <p>2. Prevent insect bites</p> <ul style="list-style-type: none"> • Repellents (DEET ≥ 30%), spray clothing with insecticide (permethrin) • Sleep under bednet • Malaria chemoprophylaxis/emergency standby treatment⁽ⁱⁱ⁾ • Yellow fever, see page 66 • Leishmaniasis beware of sand flies (dogs)

Advice on travel restrictions, see <http://www.hivtravel.org>

- i Higher susceptibility due to HIV-associated GALT destruction, low CD4 count.
- ii According to malaria risk at travel destination and national guidelines; adherence counselling is particularly important in persons visiting friends and relatives. See [Drug-drug Interactions between Antimalarial Drugs and ARVs](#).

Drug-drug Interactions between Antimalarial Drugs and ARVs

Antimalarial drugs	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
First line and second line drugs	amodiaquine	↔	↑	↔	↑	↑ ^c	↓?	↓29% ^c	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	artemisinin	↑	↑	↑	↑	↓ ≈50%	↓D	↓D	D	D	D	↔	↑	↔	↔	↔	↔	↔	↔
	atovaquone	↔	↓46% ^a	↔	↓ ^a	↓74% ^a	↓75% ^a	↓E55% ^a	↓ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	chloroquine	↔ ^b	↔ ^b	↔	↔	↔ ^b	↔	↔	↔	↔ ^e	↔	↔	↔	↔	↔	↔	↔	↔	↔
	clindamycin	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔
	doxycycline	↔	↔	↔	↔	↔	↓?	↓?	↓?	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	lumefantrine	↑ ^b	↑ ^b	↑	↑	↑ ^b	↓ ≈40%	↓	↓D46%	↔ ^e	↔	↔	↔	↑	↔	↔	↔	↔	↔
	mefloquine	↑ ^b	↑ ^b	↑	↑	↑ ^b	↓	↓	↓	↔ ^e	↔	↔	↔	↑	↔	↔	↔	↔	↔
	primaquine	↔	↔	↔	↔	↔	↔ ^d	↔ ^d	↔ ^d	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	proguanil	↔	↓41% ^a	↔	↓ ^a	↓38% ^a	↓44% ^a	↓E55% ^a	↓ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	pyrimethamine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E	E	↔	↔
	quinine	↑ ^b	↑ ^b	↑	↑	↑ ^b	↓	↓	↓	↔ ^e	E	↔	↔	↑	↔	↔	↔	↔	↔
	sulfadoxine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	E	E	↔	↔

Legend

- ↑ potential increased exposure of the antimalarial drug
- ↓ potential decreased exposure of the antimalarial drug
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a take with high fat meal, consider dose increase
- ^b ECG monitoring is recommended
- ^c liver toxicity
- ^d increase of haemotoxic metabolites
- ^e both drugs can induce QT interval prolongation (only at supratherapeutic dose for rilpivirine)

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Note: interactions with ZDV: amodiaquine, atovaquone, primaquine, pyrimethamine, sulfadoxine (potential additive hematological toxicity)

Vaccination

<ul style="list-style-type: none"> • Vaccinate according to national guidelines for healthy population, preferably after having achieved suppressed viraemia and immune reconstitution (CD4 count > 200 cells/μL) • Consider repeating vaccinations performed at CD4 count < 200 cells/μL (< 14%) or unsuppressed viraemia once adequate immune reconstitution is achieved (HIV-VL undetectable and CD4 count > 200 cells/μL) • As vaccine responses may be significantly lower in HIV-positive persons (i.e. lower seroconversion rates, faster titer decline), consider antibody titers to assess their effectiveness • Avoid polysaccharide vaccination • For background data, see http://www.bhiva.org/vaccination-guidelines.aspx. 	<ul style="list-style-type: none"> • For attenuated live vaccines⁽ⁱ⁾ (in addition to restrictions for general population): <ul style="list-style-type: none"> • *Varicella, measles, mumps, rubella, yellow fever Contraindicated if CD4 count < 200 cells/μL (14%) and/or AIDS. Impaired protection after vaccination with unsuppressed viraemia. • Oral live typhoid Contraindicated if CD4 count < 200 cells/μL (14%); give inactivated parenteral polysaccharide vaccine. Preferred if CD4 count > 200 cells/μL (> 14%).
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Infection	Vaccination rationale in HIV-positive persons	Comment
Influenza Virus	Higher rate of pneumonia. Explicitly recommended in all HIV-positive persons	Yearly
Human Papilloma Virus (HPV)	Shared risk with HIV of contracting infection. Higher rate of cervical and anal cancer	Vaccinate with 3 doses for all HIV-positive persons up to age 26 / age 40 if MSM (health insurance coverage differs by country according to age, sex, sexual orientation). Use 9-valent vaccine if available. If HPV infection is established, efficacy of vaccine is questionable
Hepatitis B Virus (HBV)	Shared risk with HIV of contracting infection. HIV accelerates liver disease progression	Vaccinate if seronegative. Repeat doses until anti-HBs antibodies ≥ 10 IU/L / ≥ 100 IU/L according to national guidelines. In order to reach ≥ 100 IU/L in non-responders repeat 3 doses if anti-HBs < 10 IU/L, 1 dose if anti-HBs < 100 IU ⁽ⁱⁱ⁾ ; consider double dose (40 μg) in particular with low CD4 count and high HIV-VL. See page 81
Hepatitis A Virus (HAV)	According to risk profile (travel, MSM, IDU, active hepatitis B or C infection)	Vaccinate if seronegative. Consider checking antibody titres in individuals with high risk. Weaker immune response expected with HAV/HBV co-vaccine. See page 81
<i>Neisseria meningitidis</i>	As general population	Use conjugated ⁽ⁱⁱⁱ⁾ vaccine (2 doses 1-2 months apart) if available. Booster every five years if exposure continues. Polysaccharide vaccine not recommended anymore.
<i>Streptococcus pneumoniae</i>	Higher rate and severity of invasive disease. Vaccine explicitly recommended for all HIV-positive persons	One dose of conjugated ⁽ⁱⁱⁱ⁾ 13-valent vaccine (CPV-13) for all individuals, also if pre-vaccinated with PPV-23 polysaccharide vaccine. No general recommendation for any booster dose. Some national guidelines consider one dose of PPV-23 at least 2 months after CPV-13 for all individuals.
Varicella Zoster Virus (VZV)	Higher rate and severity of both chickenpox and zoster	Perform serology if exposure history negative. Vaccinate if seronegative. For contraindications, see*
Yellow Fever Virus	Mandatory for travel to selected countries (provide exemption letter if no true risk of exposure)	Contraindicated if past or current haematological neoplasia or thymus affection (thymoma, resection/radiation) For other contraindications, see*. Booster q 10 years.

- i Administer live vaccines simultaneously or with an interval of 4 weeks
 ii In case of non-response, ART should contain TDF or TAF
 iii Conjugated vaccines are more immunogenic, induce memory cells, respond to boosting and reduce mucosal colonisation

Sexual and Reproductive Health of HIV-positive Women and Men

Screening questions about sexual and reproductive health and sexual functioning should be routinely asked in every HIV consultation.

Sexual transmission of HIV

Effective measures to reduce sexual transmission of HIV include:

Measure	Comment
Male condom or female condom use	<ul style="list-style-type: none"> Effective in treated and untreated HIV-positive persons
Post-exposure prophylaxis (PEP)	<ul style="list-style-type: none"> Consider after situations of unprotected anal or vaginal intercourse, if one partner has detectable HIV-VL and the other partner is seronegative Start as soon as possible and within 48/72 hours post sexual exposure See Post-exposure prophylaxis (PEP)
Pre-exposure prophylaxis (PrEP)	<ul style="list-style-type: none"> Effective in HIV-negative persons with high risk sexual situations, see Pre-exposure prophylaxis (PrEP)
ART for HIV-positive partner	<ul style="list-style-type: none"> Considered effective from 6 months of fully suppressive ART if no active STIs Consider in e.g. serodifferent couplesⁱ

ⁱ See page 11

STI screening and treatment

STI screening should be offered to all sexually active HIV-positive persons at the time of HIV diagnosis, annually thereafter or at any time STI symptoms are reported and during pregnancy. Diagnosis procedures should follow local or national guidelines. More comprehensive advice can be found at <http://www.iusti.org/regions/Europe/euroguidelines.htm>

The following STIs should be universally considered in HIV-positive persons and their sexual partner(s):

	Therapy	Comment
Chlamydia infection	<p>Consider doxycycline (100 mg bid po 7-10 days, contraindicated in pregnancy) or azithromycin (1 g po as a single dose) for urethritis and cervicitis.</p> <p>For <i>Lymphogranuloma venereum</i> (LGV) doxycycline (100 mg po bid for 21 days) or azithromycin (1 g po every week for 3 weeks).</p> <p>Alternatives: erythromycin (500 mg/6 h poⁱ) or levofloxacin (500 mg/day) for 7 days (or 21 days in case of LGV)</p>	<ul style="list-style-type: none"> May cause therapy-resistant proctitis in HIV-positive MSM Consider co-infections with <i>Neisseria gonorrhoeae</i>
Gonorrhoea	Ceftriaxone (500 mg im as a single dose) together with azithromycin (1 g po as a single dose).	<ul style="list-style-type: none"> Can cause proctitis, prostatitis and epididymitis In women often asymptomatic Fluoroquinolone resistance is highly prevalent in all regions
HBV infection HCV infection	See detailed information on HIV/HCV or HIV/HBV co-infections, pages 82-87	<ul style="list-style-type: none"> Interruption of TDF, 3TC or FTC can lead to HBV reactivation Clusters of acute HCV infection in HIV-positive MSM across Europe
HPV infection	<p>There are several treatment modalities for the management of genital warts with no evidence to suggest one approach is better than another approach. Consider operative removal by laser surgery, infrared coagulation, cryotherapy, etc.</p> <p>Management of both pre-invasive cervical lesions as well as peri- and intra-anal lesions should follow local or national guidelines</p>	<ul style="list-style-type: none"> Infection is mostly asymptomatic; relapse of genital warts is frequent Cervical PAP smear test recommended in all HIV-positive women Anal HPV screening and cytology should be considered in all HIV-positive persons practising anal sex Consider high resolution anoscopy in case of suspicious cytological findings (rectal palpation or external inspection is not sufficient)
HSV2 infection	Primary infection: aciclovir (400–800 mg po tid) or valaciclovir (500 mg po bid) for 5 days, see page 93	<ul style="list-style-type: none"> Treatment of HSV2 alone does not prevent HIV-transmission and only modestly prevents HIV disease progression
Syphilis	<p>Penicillin is the gold standard for the treatment of syphilis in both pregnant and non-pregnant individuals.</p> <p>Primary/secondary syphilis: benzathine penicillin G (2.4 million IU im as single dose). In early syphilis adjunctive treatment with prednisolone (20–60 mg daily for 3 days) prevents optic neuritis, uveitis and Jarisch–Herxheimer reaction.</p> <p>Late latent syphilis and syphilis of unknown duration: benzathine penicillin (2.4 million IU im weekly on days 1, 8 and 15); the alternative doxycycline (100 mg po bid for 2 weeks) is considered less effective.</p> <p>Neurosyphilis: penicillin G (6 x 3 - 4 million IU iv for at least 2 weeks).</p> <p>There is no evidence to give a general recommendation on prednisolone use in this condition.</p>	<ul style="list-style-type: none"> Expect atypical serology and clinical courses Consider cerebrospinal fluid (CSF) testing in persons with neurological symptoms (evidence for intrathecal-produced specific antibodies, pleocytosis, etc.) Successful therapy clears clinical symptoms and decreases VDRL test four-fold within 6-12 months

ⁱ Rarely used

Reproductive health

Reproductive health issues should be preferentially discussed with both partners, particularly in serodifferent couples. See [Drug-drug Interactions between Contraceptives and ARVs](#)

Approaches for serodifferent couples who want to have children

Screening for STIs (and treatment, if required) of both partners is mandatory. For HIV-positive women wishing to conceive:

- (1) avoid using ddI, d4T or triple NRTIs, among PI/r, prefer ATV/r, already started NVP, EFV, DTG, RAL or DRV/r can be continued. Women on EVG/c need to be informed that monitoring of HIV-VL and drug levels may be necessary during pregnancy, see page 17;
- (2) consider treating the HIV-positive partner to reduce risk of HIV transmission to the HIV-negative partner.

No single method is fully protective against transmission of HIV; the following list represents selected measures with increasing safety for serodifferent couples without active STIs:

- Unprotected intercourse during times of maximum fertility (determined by ovulation monitoring), if the HIV-positive partner has undetectable HIV-VL.
- Vaginal syringe injection of seminal fluid during times of maximum fertility, if the male partner is HIV-negative.
- Sperm washing, with or without intra-cytoplasmic sperm injection, is no longer necessary because of effectiveness of ART in avoiding HIV transmission at conception in HIV-positive male persons with undetectable HIV-VL.

Sexual dysfunction

Guidelines for treatment of sexual dysfunction in the general population are available for men but not women. Refer to specialist where appropriate. See [Sexual Dysfunction](#) and [Treatment of Sexual Dysfunction in HIV-positive Men](#)

Sexual Dysfunction

When sexual complaints exist:	What is the exact nature of the problem? In which phase(s) of the sexual response cycle does the problem occur?	1. Desire (lack of sexual desire or libido; desire discrepancy with partner; aversion to sexual activity) 2. Arousal (difficulties with physical and/or subjective sexual arousal; difficulties or inability to achieve or sustain an erection of sufficient rigidity for sexual intercourse MEN; i.e. erectile dysfunction; lack or impaired nocturnal erections MEN; difficulties lubricating WOMEN; difficulties sustaining arousal) 3. Orgasm (difficulties experiencing orgasm) 4. Pain (pain with sexual activity; difficulties with vaginal/anal penetration–anxiety, muscle tension; lack of sexual satisfaction and pleasure)	
	Self-assessment of sexual function (questionnaires):	MEN International Index of Erectile Function (IIEF) -5, see https://www.hiv.va.gov/provider/manual-primary_care/urology-tool2.asp or IIEF-15, see http://files.sld.cu/urologia/files/2011/08/iief.pdf WOMEN Female Sexual Function Index (FSFI), see http://www.fsquestionnaire.com	
Check for endocrine causes:	Signs of hypogonadism	MEN - Look for signs of testosterone insufficiency (main: decreased or absent nocturnal erections, decrease in testes size, decreased volume of ejaculate, hot flushes, sweats, reduction of body hair and beard; others: reduced sexual arousal and libido, decreased frequency of sexual thoughts and fantasies, decreased genital sensitivity, erectile dysfunction, loss of vitality; fatigue; loss of muscle mass and muscle strength) - If signs or symptoms of hypogonadism are present ask for hormonal assessment: luteinizing hormone (LH), follicle stimulating hormone (FSH), total testosterone; sex hormone-binding globulin evaluation to calculate free testosterone, see http://www.issam.ch/freetesto.htm	If hypogonadism is present (total testosterone < 300 ng/dl or calculated free testosterone below normal): refer to endocrinologist or andrologist If hypogonadism is not present: check for other causes
		WOMEN - Look for signs of estradiol insufficiency/menopause (amenorrhoea or missed menstrual periods, vaginal dryness, hot flashes, night sweats, sleep disturbances, emotional lability, fatigue, recurrent urogenital infections) - If symptoms of menopause are present ask for hormonal assessment: LH, FSH, estradiol	If symptoms of menopause are present: refer to endocrinologist or gynaecologist If hypogonadism is not present: check for other causes
	Psychological or sociological problems	Stigma, body image alteration, depression, fear of infecting an HIV-negative partner, anxiety, awareness of a chronic disease, condom use	Refer to clinical psychologist
	Infections	MEN - Urogenital infections (note: if complete sexual response possible, e.g. with another partner, with masturbation or nocturnal erections-then no major somatic factors are involved) WOMEN - Urogenital infections	Refer to urologist, andrologist, cardiologist Refer to gynaecologist
Check for other causes:	Relevant medicines, drugs, lifestyle factors	Drugs associated with sexual dysfunction: 1) Psychotropics – MEN and WOMEN (antidepressants, antiepileptics, antipsychotics, benzodiazepines), 2) Lipid-lowering drugs - MEN (statins, fibrates), 3) Antihypertensives - MEN (ACE-inhibitors, betablockers, alfablockers), 4) Others – MEN and WOMEN (omeprazole, spironolactone, metoclopramide, finasteride, cimetidine); 5) MEN and WOMEN - contribution from ARVs is controversial and benefit from switching studies is not proven	Consider therapy changes

Treatment of Sexual Dysfunction in HIV-positive Men

Treatment of erectile dysfunction	Treatment of premature ejaculation
<p>Primarily oral PDE5-inhibitors (sildenafil, tadalafil, vardenafil).</p> <ul style="list-style-type: none">• All at least 30 minutes before initiation of sexual activity• Use lower dose if on PI/r<ul style="list-style-type: none">— sildenafil (25 mg every 48 hours)— tadalafil 5 mg initial dose with maximum dose 10 mg in 72 hours— vardenafil 2.5 mg maximum dose in 72 hours• Tadalafil also licensed for use as an everyday ongoing therapy	<p>Consider behavioural interventions and/or psychosexual counselling, SSRIs, tricyclic antidepressants, clomipramine and topical anaesthetics.</p> <ul style="list-style-type: none">• Use lower dose of clomipramine and other tricyclic antidepressants if on PI/r• Dapoxetine, a short-acting SSRI, is the only drug approved for on-demand treatment of premature ejaculation in Europe.• Treatment must be maintained as recurrence is highly likely following withdrawal of medicine

Depression: Screening and Diagnosis

Significance

- Higher prevalence of depression reported in HIV-positive persons (20-40% versus 7% in general population)
- Significant disability and poorer HIV treatment outcomes associated with depression

Screening and diagnosis

Who?	How to screen?	How to diagnose?
<p>Screening of all HIV-positive persons recommended in view of the high prevalence of depression</p> <p>Populations at particularly high risk</p> <ul style="list-style-type: none"> • Positive history of depression in family • Depressive episode in personal history • Older age • Adolescence • Persons with history of drug addiction, psychiatric, neurologic or severe somatic co-morbidity • Use of EFV • Use of neurotropic and recreational drugs • As part of investigation of neuro-cognitive impairment, see page 74 	<ul style="list-style-type: none"> • Screen every 1-2 years • Two main questions: <ol style="list-style-type: none"> 1. Have you often felt depressed, sad or without hope in the last few months? 2. Have you lost interest in activities that you usually enjoy? • Specific symptoms in men: <ul style="list-style-type: none"> – Stressed, burn out, angry outbursts, coping through work or alcohol • Rule out organic cause (such as hypothyroidism, hypogonadism, Addison's disease, non-HIV drugs, vitamin B12 deficiency) 	<p>Symptoms – evaluate regularly</p> <p>A. At least 2 weeks of depressed mood OR</p> <p>B. Loss of interest OR</p> <p>C. Diminished sense of pleasure</p> <p>PLUS 4 out of 7 of the following:</p> <ol style="list-style-type: none"> 1. Weight change of $\geq 5\%$ in one month or a persistent change of appetite 2. Insomnia or hypersomnia on most days 3. Changes in speed of thought and movement 4. Fatigue 5. Feelings of guilt and worthlessness 6. Diminished concentration and decisiveness 7. Suicidal ideation or a suicide attempt⁽ⁱ⁾

ⁱ EFV has been associated with a higher risk of suicidal ideation

Depression: Management

Degree of depression	Number of symptoms (see page 70: A, B or C + 4/7)	Treatment	Consultation with expert
No	< 4	No	
Mild	4	<ul style="list-style-type: none"> • Problem-focused consultation • Consider antidepressant treatment⁽ⁱ⁾ • Recommend physical activity 	<ul style="list-style-type: none"> • Always if treating doctor is unfamiliar with use of antidepressants • If depression not responding to treatment • If person has suicidal ideation • In case of complex situations such as drug addiction, anxiety disorders, personality disorders, dementia, acute severe life events
Intermediate	5-6	Start antidepressant treatment ⁽ⁱ⁾	
Severe	> 6	Refer to expert (essential)	

ⁱ See [Drug-drug Interactions between Antidepressants and ARVs](#)

If a person is diagnosed with depression switching off EFV to another third ARV drug according to switch rules is recommended.

Classification, Doses, Safety and Adverse Effects of Antidepressants

Mechanisms & classification	Start dose	Standard dose	Lethality in overdose ⁽ⁱ⁾	Insomnia and agitation	Sedation	Nausea or GI effects	Sexual dysfunction	Weight gain
	mg/day							
Selective serotonin-reuptake inhibitors (SSRIs) ⁽ⁱ⁾								
paroxetine	10-20	20-40	Low	+	- / +	+	++	++
sertraline	25-50	50-150	Low	+	- / +	+	+	+
citalopram	10-20	20-40	Low	+	- / +	+	+	+
escitalopram	5-10	10-20	Low	+	- / +	+	+	+
Mixed or dual-action reuptake inhibitors								
venlafaxine	37.5-75	75-225	Moderate	++	- / +	+	+	- / +
Mixed-action newer agents								
mirtazapine	30	30-60	Low	- / +	++	- / +	- / +	++

- none
+ moderate
++ severe

- i** For many persons, SSRI induction may be associated with adverse effects (GI tract, dizziness, anxiety, panic attacks). Commencing at lower doses (i.e. 10, 25 & 10 mg for paroxetine, sertraline and citalopram, respectively) and increasing to the above starting doses after 4 to 7 days if tolerated may reduce such effects.
- ii** Insomnia is associated with DTG containing ART regimens and with the use of some antidepressants. Clinicians should be aware when prescribing DTG and antidepressants together.

Drug-drug Interactions between Antidepressants and ARVs

Antidepressants		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL
SSRI	citalopram	↑ ^a	↑ ^a	↑	↑	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑	↔
	escitalopram	↑ ^a	↑ ^a	↑	↑	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑	↔
	fluvoxamine	↑	↑	↑	↑	↑	↔	↔	E	↔	↔	↔	↔	↑	↔
	fluoxetine	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	paroxetine	↑↓?	↑↓?	↑↓?	↓39%	↑↓?	↔	↔	↔	↔	↔	↔	↔	↑↓?	↔
	sertraline	↑	↓	↑	↓49%	↓	↓39%	↓	↓	↔	↔	↔	↔	↓7%	↔
SNRI	duloxetine	↑	↑↓	↑	↑↓	↑↓	↔	↔	↔	↔	↔	↔	↔	↑	↔
	venlafaxine	↑	↑	↑	↑	↑	↓	↓	↓	↔	D	↔	↔	↑	↔
TCA	amitriptyline	↑ ^a	↑ ^a	↑	↑	↑ ^a	↔	↔	↔	↔ ^b	↔	↔	↔	↑	↔
	clomipramine	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑ ^a	↔
	desipramine	↑ ^a	↑ ^a	↑	↑	↑5% ^a	↔	↔	↔	↔ ^b	↔	↔	↔	↑	↔
	doxepin	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	imipramine	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑ ^a	↔
	nortriptyline	↑ ^a	↑ ^a	↑	↑	↑ ^a	↔	↔	↔	↔ ^b	↔	↔	↔	↑	↔
TeCA	trimipramine	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	maprotiline	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔
	mianserine	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔
Oth-ers	mirtazapine	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔
	bupropion	↔	↓	↔	↓	↓57%	↓55%	↔	↓	↔	↔	↔	↔	↑?	↔
	lamotrigine	↔	↓32%	↔	↓	↓50%	↓	↔	↔	↔	↔	↔	↔	↔	↔
	nefazodone	↑	↑	↑	↑	↑	↓E	↓E	↓E	E	E	E	↔	↑	↔
	St John's wort	D	D	D	D	D	D	D	D	D	D	D	D ^c	D	D
	trazodone	↑ ^a	↑ ^a	↑	↑	↑ ^a	↓	↓	↓	↔ ^b	↔	↔	↔	↑	↔

Legend

- ↑ potential elevated exposure of the antidepressant
- ↓ potential decreased exposure of the antidepressant
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a ECG monitoring is recommended
- ^b caution as both drugs can induce QT interval prolongation
- ^c the US Prescribing Information recommends that co-administration should be avoided as there are insufficient data to make dosing recommendations

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Numbers refer to decreased AUC of the antidepressant as observed in drug-drug interactions studies.

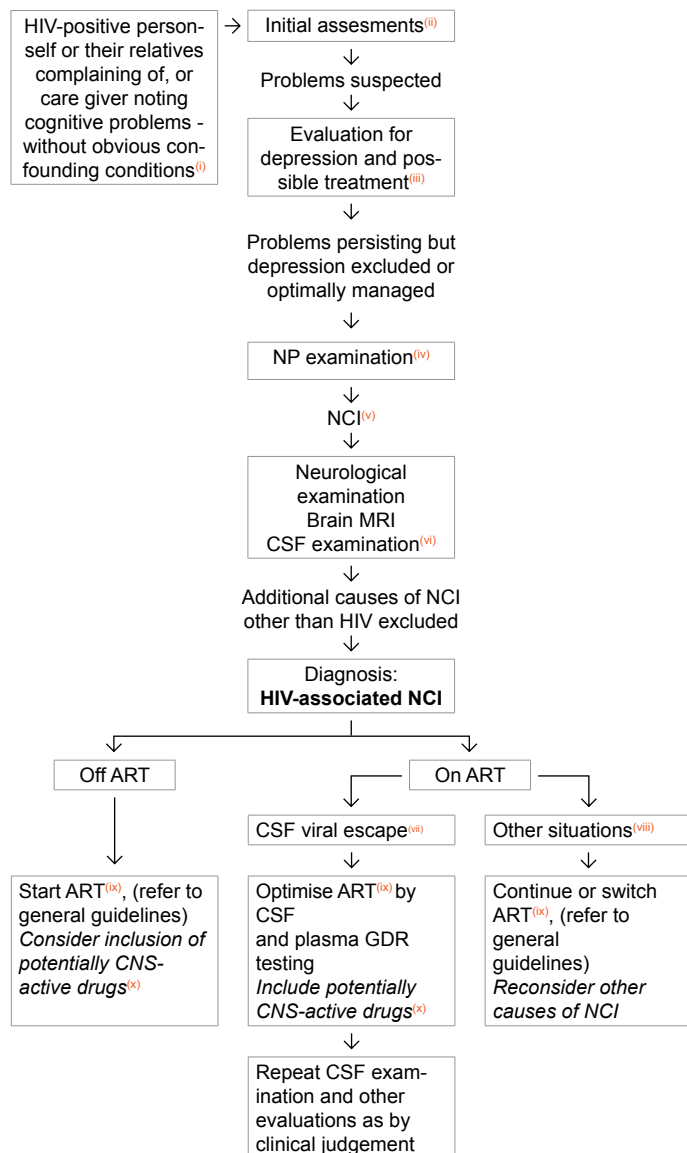
Note: no clinically relevant interactions expected between ZDV (or any other NRTI) and antidepressants

- SSRI** selective serotonin reuptake inhibitors
- SNRI** serotonin and norepinephrine reuptake inhibitors
- TCA** tricyclic antidepressants
- TeCA** tetracyclic antidepressants

Algorithm for Diagnosis and Management of HIV-Associated Neurocognitive Impairment (NCI) in Persons without Obvious Confounding Conditions

Abbreviations

CSF	cerebrospinal fluid
GDR	genotypic drug resistance test
HAD	HIV-associated dementia
MND	mild neurocognitive disorder
MRI	brain magnetic resonance imaging
NP	neuropsychological
OIs	opportunistic infections



i Obvious confounding conditions:

1. Severe psychiatric conditions
2. Abuse of psychotropic drugs
3. Alcohol abuse
4. Sequelae from previous CNS-OIs or other neurological diseases
5. Current CNS-OIs or other neurological diseases

ii The following questions may be used to guide doctor assessment

1. Do you experience frequent memory loss (e.g. do you forget the occurrence of special events even the more recent ones, appointments, etc.)?
 2. Do you feel that you are slower when reasoning, planning activities, or solving problems?
 3. Do you have difficulties paying attention (e.g. to a conversation, book or movie)?
- Answering "yes" to one or more of these questions may suggest the presence of cognitive disorders, although not necessarily linked to HIV.

iii See [Depression: Screening and Diagnosis](#)

iv NP examination will have to include tests exploring the following cognitive domains: fluency, executive functions, speed of information processing, attention/working memory, verbal and visual learning, verbal and visual memory, motor skills plus assessment of daily functioning.

v NCI is defined by impairment in cognitive function on the above neuropsychological test where performance is compared to age- and education-matched appropriate controls and is considered clinically significant.

vi Neurological examination, brain MRI and CSF examination are required to exclude other pathologies and to further characterise HIV-associated NCI by including assessment of CSF HIV-VL level and, where appropriate, evidence for genotypic drug resistance (GDR) in a paired CSF and plasma sample.

vii CSF escape definition:

either CSF HIV-VL detectable and plasma HIV-VL undetectable; or both CSF HIV-VL and plasma HIV-VL detectable, with CSF HIV-VL higher than plasma HIV-VL.

viii Including all situations that do not fulfill the CSF escape definition

ix Triple ART regimen

x ART drugs with potential beneficial or detrimental effects on the CNS

Definition of potentially CNS-active drug

ARV drugs with either:

1. demonstrated clear CSF penetration when studied in healthy HIV-positive populations (concentration above the IC90 in > 90% examined persons)
2. proven short-term (3-6 months) efficacy on cognitive function or CSF HIV-VL decay when evaluated as single agents or in controlled studies in peer-reviewed papers

• Drugs with demonstrated clear CSF penetration:

- NRTIs: ZDV, ABC*
- NNRTIs: EFV**, NVP
- PI/r: LPV/r, DRV/r*
- INSTI: DTG
- Other classes: MVC

• Drugs with proven clinical efficacy:

- NRTIs: ZDV, ABC
- PI/r: LPV/r

* When administered bid. Once-daily administration of these drugs, although common in clinical practice, has not been studied extensively with regard to CNS effects/CSF penetration and may have different CNS activity. RTV is preferred as PI booster

** Avoid EFV because of its detrimental effects on neurocognitive function in a RCT and potentially confounding CNS effects due to neuropsychiatric effects.

See online video lectures [CNS and HIV-Part 1](#) and [CNS and HIV-Part 2](#) from the EACS online course Clinical Management of HIV.

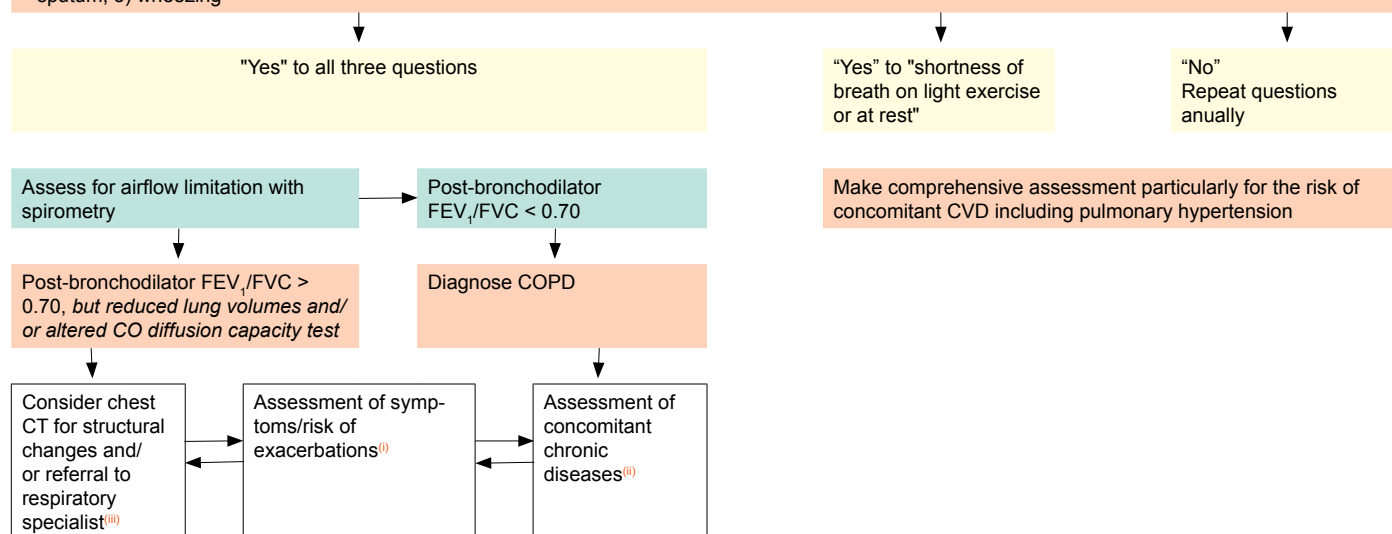
Chronic Lung Disease in HIV

Screen for chronic lung disease:

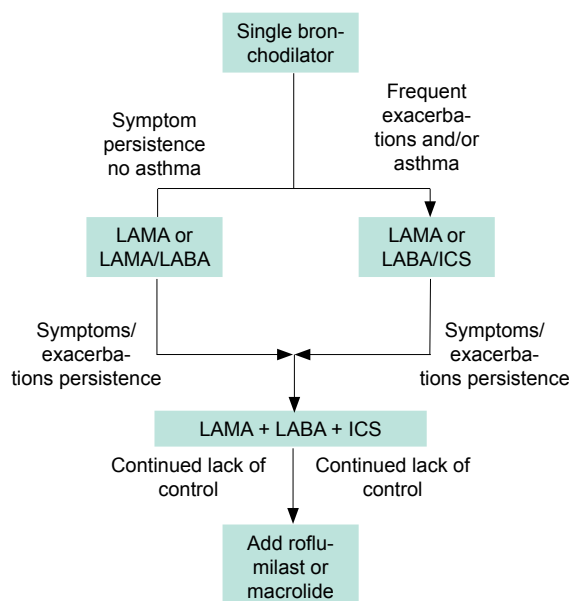
- Are you 40 years or older?
- Have you smoked more than 10 pack years in your entire lifetime?

Then check for respiratory symptoms:

- Do you have ANY of the following on a regular basis: 1) shortness of breath when walking up a slight hill or hurrying on flat ground; 2) cough and/or sputum; 3) wheezing



Treatment of COPD^(iv)



LABA: long-acting β_2 -agonist
LAMA: long-acting muscarinic antagonist
ICS: inhaled corticosteroid

There are 3 life saving interventions:

1. Smoking cessation
2. Chronic oxygen when stable (non-exacerbated) resting $SpO_2 \leq 88\%$ (or $PaO_2 \leq 55$ mmHg)
3. Non-invasive ventilation (NIV) in individuals with acute hypercapnic respiratory failure

- i Assessment of either dyspnoea using mMRC, see <https://www.verywell.com/guidelines-for-the-mmrc-dyspnea-scale-914740> or symptoms using CATTM, see <http://www.catestonline.org/> and history of exacerbations (including prior hospitalisations)
- ii COPD itself has significant extra-pulmonary (systemic) effects including weight loss, nutritional abnormalities and skeletal muscle dysfunction
- iii Based on expert opinion
- iv Each pharmacological treatment should be individualised and guided by the severity of symptoms, risk of exacerbations, adverse effects, co-morbidities, drug availability and cost, and the individual's response, preference and ability to use various drug delivery devices. Inhaler technique needs to be assessed regularly. Long-term use of oral glucocorticoids has no evidence of benefits in COPD. Because of the risk of pneumonia and because of proven superiority of LABA/LAMA over LABA/ICS, the addition of ICS to LABA is recommended only in individuals with history of frequent exacerbations and/or asthma or in individuals not adequately controlled by LAMA/LABA combination. Do not use inhaled glucocorticoids with boosted ART regimens, see [Drug-drug Interactions between Corticosteroids and ARVs](#). Influenza and pneumococcal vaccination decreases rates of lower respiratory tract infections, see [Vaccination](#)

Drug-drug Interactions between Bronchodilators (for COPD) and ARVs

Bronchodilators		ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
LAMA	acclidinium bromide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	glycopyrronium bromide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	tiotropium bromide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	umeclidinium bromide	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
SAMA	ipratropium	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
LABA	formoterol	↔ ^a	↔ ^a	↔	↔	↔ ^a	↔	↔	↔	↔ ^a	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	indacaterol	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↑ ^d	↓	↓	↓	↔	↔	↔	↔	↑ ^d	↔	↔	↔	↔	↔	↔
	olodaterol	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	salmeterol	↑ ^b	↑ ^b	↑ ^b	↑ ^b	↑ ^b	↓	↓	↓	↔ ^a	↔	↔	↔	↔	↑ ^b	↔	↔	↔	↔	↔
	vilanterol	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
SABA	salbutamol (albuterol)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
MX	aminophylline	↔	↓	↔	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	theophylline	↔	↓	↔	↓	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
PDE4	roflumilast	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
ICS	beclometasone	↑ ^c	↑ ^c	↑ ^c	↓11%	↑ ^c	↔	↔	↔	↔	↔	↔	↔	↑ ^c	↔	↔	↔	↔	↔	↔
	budesonide	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	fluticasone	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of the bronchodilator
- ↓ potential decreased exposure of the bronchodilator
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a caution as both drugs can induce QT interval prolongation
- ^b ECG monitoring is recommended
- ^c increase in concentration of active metabolite observed with RTV 100 mg bid alone but without significant effect on adrenal function. Caution is still warranted, use the lowest possible corticosteroid dose and monitor for corticosteroid side effects
- ^d exposure can be increased up to 2-fold however this increase does not raise any concerns based on indacaterol's safety data

ICS inhaled corticosteroids
LABA long-acting β₂ agonists
LAMA long-acting muscarinic antagonists
MX methylxanthines
PD4 phosphodiesterase 4 inhibitors
SABA short-acting β₂ agonists
SAMA short-acting muscarinic antagonists

Note: no clinically significant interactions expected between ZDV and bronchodilators

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Drug-drug Interactions between Pulmonary Antihypertensives and ARVs

Pulmonary antihypertensives	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
ERA	ambrisentan	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	bosentan	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓	↓	↓ ^b	D	D	D	D	↑ ^a	↔	↔	↔	↔	↔	↔
	macitentan	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
PDE5	sildenafil	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	tadalafil	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
sGC	riociguat	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
PA	epoprostenol	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	iloprost	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	treprostinil	↔	↑	↔	↑	↑	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
IPr	selexipag	↔ ^c	↔ ^c	↔ ^c	↔ ^c	↔ ^c	↔	↔	↔	↔	↔	↔	↔ ^c	↔	↔	↔	↔	↔	↔

Legend

- ↑ potential increased exposure of the pulmonary antihypertensive
- ↓ potential decreased exposure of the pulmonary antihypertensive
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug
- ATV/c ATV co-formulated with COBI (300/150 mg qd);
- DRV/c DRV co-formulated with COBI (800/150 mg qd)
- ^a when starting bosentan in individuals already on PI/r, PI/c or EVG/c use a bosentan dose of 62.5 mg qd or every other day. Discontinue bosentan at least 36 h prior to starting PI/r, PI/c or EVG/c and restart after at least 10 days at 62.5 mg qd or every other day
- ^b potential additive liver toxicity
- ^c exposure of parent drug increased but exposure of active metabolite unchanged

- ERA** endothelin receptor antagonists
- IPr** IP receptor agonists
- PA** prostacyclin analogues
- PDE5** phosphodiesterase type 5 inhibitors
- sGC** soluble guanylate cyclase stimulators

Note: no clinically significant interactions expected between ZDV and pulmonary antihypertensives

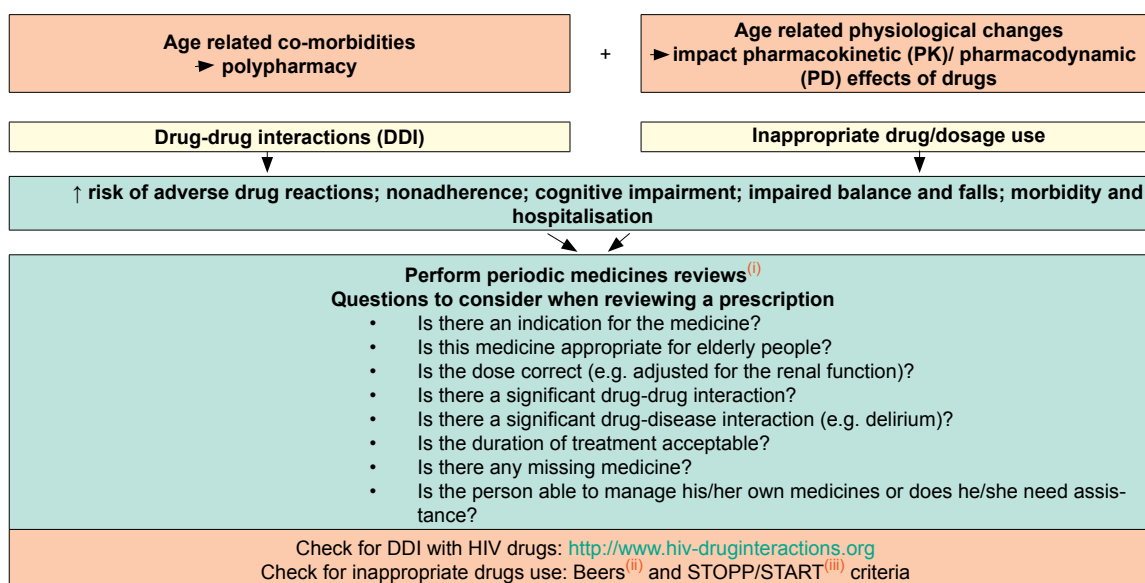
Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Prescribing in the Elderly



Adapted from [10], [11], [12]

i-iii The Beers and STOPP criteria are tools established by experts in geriatric pharmacotherapy to detect and reduce the burden of inappropriate prescribing in elderly. Inappropriate medicines include, for instance, those which in elderly persons with certain diseases can lead to drug-disease interactions, are associated with a higher risk of adverse drug reactions in the elderly, medicines that predictably increase the risk of falls in the elderly or those to be avoided in case of organ dysfunction. The START criteria consist of evidence-based indicators of potential prescribing omission in elderly with specific medical conditions.

Solid Organ Transplantation (SOT) in HIV-Positive Persons

General features

- HIV infection is not a contraindication for transplantation consideration.
- Experts in HIV medicine should preferably be members of the multi-disciplinary team, responsible for the pre-transplant evaluation, and take primary responsibility for the management of the HIV infection and the prevention and treatment of OIs.

Organ criteria for SOT

- HIV-positive persons should be considered for organ transplantation using the same indications as used in HIV-negative persons. HIV-positive persons with HCC can be evaluated for liver transplantation if they fulfill the Milan criteria⁽⁹⁾.

Organ donation

- HIV-positive persons can receive organs from living (renal) and deceased (all types of SOT) HIV-negative donors.
- The use of HIV-positive donor organs for HIV-positive recipients is being evaluated in the context of research studies.

HIV-infection criteria for SOT

According to most international guidelines, HIV-positive individuals should fulfill the following criteria to be considered for SOT

1. **Clinical criteria.** No active OIs or HIV-related cancers. Individuals with PML, chronic crypto/microsporidiosis, multi-drug resistant fungal or mycobacterial infections, NHL and visceral KS to be excluded. For non-HIV-related cancers same criteria apply as in the general HIV-negative population.
2. **Immunological criteria.** CD4 > 200 cells/μL for all SOT except for liver transplantation where CD4 > 100 cells/μL. Persons with previous opportunistic infections should have a CD4 > 200 cells/μL.
3. **Virological criteria.** Full control of HIV replication prior to and after transplantation should be confirmed/predicted in all cases.
4. **Drug abuse.** Abstinence period: alcohol 6 months; heroin/cocaine 2 years. Former IVDUs can be in methadone programme.

Preparing HIV-positive persons for transplantation

Antiretroviral therapy

- Choice of ART components should avoid drugs known to cause organ dysfunction or drugs with a high potential for drug-drug interactions if at all possible, see [Drug-drug Interactions between Immunosuppressants \(for SOT\) and ARVs](#).
- Using a pharmacological booster (RTV or COBI) and some of the NNRTIs are best avoided, see [Drug-drug Interactions between Immunosuppressants \(for SOT\) and ARVs](#).
- For individuals nearing indication for transplantation, ART should be modified to ensure this if at all possible.
- RAL (and probably DTG) plus 2 NRTIs is the preferred regimen.
- If the individual has not yet started ART and transplantation is considered, ART should be commenced as soon as possible and preferably before the transplantation is started.

Viral hepatitis co-infection

In liver transplant candidates, every effort should be made to treat the underlying viral hepatitis independently of MELD score, see pages [81-82](#) and [84-87](#). Use of DAAs in persons with HCV co-infection may improve their liver function, and possibly lead to them being removed from the transplant waiting list.

Prevention of infections

- While screening and treatment for latent TB is recommended in all HIV-positive persons, see page [99](#), it is particularly important in persons pre- and post-transplantation due to the additional use of immunosuppressants. Immunisation regimens and pre-transplant diagnostic protocols are the same as in HIV-negative SOT recipients.

Follow-up after transplantation

Antiretroviral therapy

- Same recommendations in individuals under preparation for transplantation.
- Additionally, ARVs may exacerbate immunosuppressive agents' adverse drug effects (kidney impairment, bone marrow suppression, drug-induced liver injury, etc.). Therefore, careful consideration of which drugs to use is essential see [Adverse Effects of ARVs & Drug Classes](#).
- Before starting or restarting abacavir containing ART the HLA-B*5701 status of the donor should be assessed.

Primary and secondary disease-specific chemoprophylaxis

- HIV-positive transplant recipients should receive the same surveillance, prophylaxis and immunisation regimens for OIs as HIV-negative SOT recipients.
- Screening and treatment for latent TB is a priority, see page [99](#).

Viral hepatitis co-infection

- The efficacy and safety of DAAs in liver transplant HIV-positive recipients with HCV recurrence is the same as in HIV-negative recipients.
- Anti HBV treatment should follow the same schedules of HIV-negative persons.

Immunosuppressive regimens

- Same as in HIV-negative transplant recipients. The risk of acute rejection is however double of that of HIV-negative SOT recipients and, therefore, requires close monitoring.
- Special attention to interaction with ART, see [Drug-drug Interactions between Immunosuppressants \(for SOT\) and ART](#).

- i Milan criteria: solitary tumor smaller than 5 cm or 2–3 tumors of < 3 cm in the absence of macrovascular tumor invasion and extrahepatic metastases.

Drug-drug Interactions between Immunosuppressants (for SOT) and ARVs

Immunosuppressants	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
CS	prednisone	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
AM	azathioprine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	mycophenolate	↔	↓	↔	↓	↓	↔	↓D13%	↔	↔	↔	↔	↔	↔	↓?	↔	↔	↔	↑E ^b
CNI	cyclosporine	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓ ^a	↓ ^a	↓ ^a	E	E	E	↔	↑ ^a	↔	↔	↔	↔	E	E ^b
	tacrolimus*	↑ ^a	↑ ^a	↑ ^a	↑ ^a	↓ ^a	↓ ^a	↓ ^a	↔	↔	↔	↔	↑ ^a	↔	↔	↔	↔	↔	↔ ^b
mTOR	everolimus	↑	↑	↑	↑	↓ ^a	↓ ^a	↓ ^a	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	sirolimus	↑	↑	↑	↑	↓ ^a	↓ ^a	↓ ^a	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔ ^b
Other	anti-thymocyte globulin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	basiliximab	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	belatacept	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

Legend

↑ potential increased exposure of the immunosuppressant
 ↓ potential decreased exposure of the immunosuppressant
 ↔ no significant effect
 D potential decreased exposure of ARV drug
 E potential elevated exposure of ARV drug
 ATV/c ATV co-formulated with COBI (300/150 mg qd);
 DRV/c DRV co-formulated with COBI (800/150 mg qd)
 * available as prolonged release formulation

Numbers refer to decreased/increased AUC of the immunosuppressant as observed in drug-drug interaction studies

^a TDM of immunosuppressant is recommended
^b monitor renal function

AM antimetabolite
CNI calcineurin inhibitors
CS corticosteroids
mTOR mTOR inhibitors

Note: interactions with ZDV: azathioprine (potential risk of additive hematotoxicity); mycophenolate (potential decrease in mycophenolate level, monitor plasma level)

Colour legend

↔ no clinically significant interaction expected
 ↓ these drugs should not be co-administered
 ↓ potential clinically significant interaction that is likely to require additional monitoring, alteration of drug dosage or timing of administration
 ↓ potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Comment

For additional drug-drug interactions and for more detailed pharmacokinetic interaction data and dosage adjustments, please refer to <http://www.hiv-druginteractions.org> (University of Liverpool).

Part IV Clinical Management and Treatment of HBV and HCV Co-infection in HIV-positive Persons

Every person with HCV/HIV co-infection should receive IFN-free DAA therapy to eradicate HCV, regardless of liver fibrosis stage in the context of faster liver fibrosis progression in co-infected persons and the availability of DAAs with excellent tolerability and efficacy. DAAs achieve similar cure rates and tolerability in HCV/HIV co-infected compared to HCV mono-infected persons. Therefore, treatment indication and regimens are the same as in HCV mono-infected persons. All persons with HBV/HIV co-infection should receive ART including TDF or TAF, unless history of tenofovir intolerance. Life-long therapy is recommended if anti-HBV nucleos(t)ides are given as part of ART. In HBsAg-positive persons without HBV active ART (including 3TC), TDF/TAF should be added as prophylaxis regardless of baseline HBV-DNA levels in case of chemotherapy or other immunosuppression (e.g. rituximab treatment) [1].

General Recommendations for Persons with Viral Hepatitis/HIV Co-infection

Screening

1. All HIV-positive persons should be screened for HCV at time of HIV diagnosis and annually thereafter. Screening should use an anti-HCV antibody test. A positive result should be followed by HCV-RNA and genotype determination. Alternatively, HCV core-antigen testing can be performed to establish chronic HCV infection. Persons with risk factors like ongoing IDU, "chem sex" (sex under the influence of recreational drugs taken predominantly intravenously immediately before and/or during sexual contacts), mucosal traumatic sex, ongoing unprotected anal intercourse, recent sexually transmitted infection) with unexplained increase in hepatic transaminases and a negative anti-HCV antibody test should be tested for HCV-RNA for early detection of a recent infection. HCV-RNA testing or HCV core antigen is also recommended in persons with high risk factors for HCV re-infection after successful treatment or spontaneous clearance at 6-monthly interval.
2. HIV-positive persons should be screened for HAV and HBV. Persons who are anti-HBc positive and HBsAg negative, in particular those with elevated liver transaminases, should be screened for HBV-DNA in addition to HBsAg to rule out occult HBV infection.
3. Hepatitis Delta antibodies should be screened for in all HBsAg positive persons.
4. HCC screening is indicated in all cirrhotic HBV or HCV co-infected persons (even if HCV infection has been cured and HBV replication is medically suppressed) in a setting where treatment for HCC is available. Although the cost-effectiveness of HCC screening in persons with F3 fibrosis is uncertain, surveillance may be considered based on an individual risk assessment, see page 58. In HBV-positive non-cirrhotics, HCC screening should follow current EASL guidelines. Risk factors for HCC in this population include family history of HCC, ethnicity (Asians, Africans), HDV and age. EASL guidelines propose using the PAGE-B score in Caucasians to assess the HCC risk, however this score has not been validated in HIV-positive persons, see pages 8, 40 and 58.
5. Routine screening is also advised for oesophageal varices in co-infected persons with liver cirrhosis, see page 57.

Vaccination, see page 66

6. Persons lacking anti-HAV IgG antibodies or anti-HBs antibodies should be offered vaccination for the respective virus to prevent infection regardless of their CD4 count. The response to the HBV vaccine is influenced by the CD4 count and level of HIV-VL. In persons with low CD4 count (< 200 cells/ μ L) and ongoing HIV replication, ART should be initiated first, prior to respective vaccination. Because of the lack of data on the impact of immunisation in isolated anti-HBc IgG positive persons (HBsAg negative, anti-HBc positive and anti-HBs negative profile), vaccination is not presently recommended in this population. Additional data awaited. However, if anti-HBc results are not available, HBV vaccination is recommended in all HBsAg negative persons.
7. In HIV-positive persons vaccinated for HBV with insufficient response (anti-HBs < 10 IU/L), re-vaccination should be considered. Double-dose (40 μ g) at 3-4 time points (months 0, 1, 6 and 12) may help to improve response rates to the HBV vaccine. Persons who fail to seroconvert after HBV vaccination and remain at risk for HBV should have annual serological tests for evidence of HBV infection. TDF based cART has been associated with prevention of HBV infection in these persons and ART including TDF or TAF is recommended.

ART

8. ART initiation is recommended in all HIV-positive persons with HBV and/or HCV co-infection irrespective of CD4 count. ART should contain TDF or TAF in HBV co-infected persons. Stopping ART has been associated with higher risk for AIDS and non-AIDS related events; indeed, the risk for non-AIDS events was particularly increased for persons with hepatitis co-infection. Stopping anti-HBV containing ART should be avoided in persons with HIV/HBV co-infection because of the high risk of severe hepatitis flares and decompensation following HBV reactivation hepatitis.

End Stage Liver Disease (ESLD)

9. HIV-positive persons with liver cirrhosis require the same measures for the treatment of oesophageal varices, hepatorenal syndrome, hepatic encephalopathy or ascites as HIV-negative persons, see page 57-58 and [Diagnosis and Management of Hepatorenal Syndrome \(HRS\)](#).
10. Persons with viral hepatitis/HIV co-infection suffering from ESLD warrant particular attention in the management of liver insufficiency; see [Dose Adjustment of ARVs for](#)

[Impaired Hepatic Function](#). Nevertheless, it is important to highlight that ART initiation in cirrhotic persons generally improves overall survival and is therefore strongly recommended in these persons.

11. Persons with HCC or a MELD-score > 15⁽¹⁾, CD4 count > 100 cells/ μ L and options for efficacious and durable ART should be evaluated for liver transplantation (OLT), see [Solid Organ Transplantation \(SOT\) in HIV-positive Persons](#).
12. Renal complications are frequent, see page 58 and [Diagnosis and Management of Hepatorenal Syndrome \(HRS\)](#).

ⁱ MELD calculation, see page 58.

Prevention/Support

13. Psychiatric, psychological, social and medical support should be made available to persons with alcohol intake to stop drinking.
14. Substitution therapy (opioid replacement therapy) in persons with active drug use as a step towards cessation of active drug use should be encouraged. Help provided (e.g. through needle and syringe exchange programme) reduces the risk of re-infection including parenteral viral transmission (harm reduction strategy), see [Drug Dependency and Drug Addiction](#).
15. Since HBV and HIV, and occasionally HCV, are transmitted sexually, adequate counselling including the use of condoms is advisable. Information on the risk of HCV transmission due to mucosal traumatic sexual practices associated with a high likelihood of blood contact or ongoing IDU, "chem sex" (sex under the influence of recreational drugs taken predominantly intravenously immediately before and/or during sexual contacts), should be provided and risk reduction should be discussed.
16. In women of childbearing age, HCV treatment should be initiated prior to conception because of the lack of safety data in pregnancy and to reduce the risk of MTCT of HCV.

Hepatitis Delta Virus

17. In persons with Delta virus co-infection and significant liver fibrosis (\geq F2), long-term (> 18 months) treatment with PEG-IFN might be considered in association with TDF-based ART. Because of its anti-HBV activity, TDF/TAF should be added to PEG-IFN in order to reduce HBV-DNA load. Treatment efficacy should be monitored with HBV-DNA and HDV-RNA measurements, when available, and with follow-up of biochemical and liver fibrosis estimates. Compassionate use of new drugs active against HDV should be encouraged in persons without response to PEG-IFN treatment. Persons with anti-HCV antibodies and detectable HCV-RNA should be offered anti-HCV treatment in order to eradicate HCV co-infection. Persistent off-treatment HDV-RNA negativity and anti-HBs seroconversion are the ideal goals of antiviral treatment for hepatitis Delta even if they can only be obtained in a minority of persons. Histological remission of liver disease is a less ambitious but more likely achievable goal. In persons with Delta virus and ESLD or HCC, liver transplantation from HBsAg negative donor should be strongly considered especially in the absence of active HCV co-infection. Transplant with anti-HBV prophylaxis post-OLT cures HBV and Delta virus infection.

Hepatitis E Virus

18. Screening in HIV-positive persons with symptoms consistent with acute hepatitis, unexplained flares of aminotransferases (even if suspected drug induced liver injury), unexplained elevated liver function tests, neuralgic amyotrophy, Guillain-Barre, encephalitis or proteinuria.
19. Screening should include anti-HEV IgG and IgM and NAT for HEV-RNA in blood and if possible in stool.
20. Treatment with RBV (600 mg daily) may be considered in cases of severe acute HEV, acute-on-chronic liver failure, extrahepatic HEV related disease or in persons with persisting HEV replication three months after first detection of HEV-RNA. RBV should be given for a duration of 12 weeks followed by HEV-RNA measurements in serum and stool. If HEV-RNA is undetectable in both, RBV can be stopped. In persons in whom HEV-RNA is still detectable in serum and/or stool, RBV may be continued for an additional three months.

Treatment of HBV/HIV Co-infection

1. All persons with HBV/HIV co-infection should receive ART that includes TDF or TAF unless history of tenofovir intolerance.
2. For HBV/HIV co-infected persons with bone mineral density changes or CKD, see recommendations for [Dose Adjustment of ARVs for Impaired Renal Function](#) and pages 49 and 52-54.
3. If TDF or TAF is strictly contraindicated, entecavir may be prescribed in persons with no prior 3TC exposure and together with fully active ART.
4. Persons with liver cirrhosis and low CD4 count require careful surveillance in the first months after starting ART in order not to overlook immune reconstitution syndrome and subsequent liver decompensation due to flares of liver enzymes (for management of cirrhotic persons, see pages 57-61). Please note that diagnosis of cirrhosis may be difficult in persons already on HBV treatment.
5. NRTI substitution should only be performed if feasible and appropriate from the perspective of maintaining HIV suppression. Caution is warranted to switch from a TDF/TAF-based regimen to drugs with a lower genetic barrier, e.g. FTC or 3TC, in particular in 3TC-pre-treated cirrhotic persons as viral breakthrough due to archived YMDD mutations is likely to happen. This has also been described in individuals with previous 3TC HBV-resistance who have been switched from TDF to entecavir.
6. The optimal treatment duration for nucleos(t)ide analogues with anti-HBV activity has not yet been determined and experts recommend life-long therapy if anti-HBV nucleos(t)ides are given as part of ART. In those on ART where the nucleoside backbone needs changing, anti-HBV therapy may be stopped cautiously in HBeAg-positive persons who have achieved HBe-seroconversion for at least one year or after confirmed HBs-seroconversion in those who are HBeAg-negative. In persons with liver cirrhosis, stopping of effective anti-HBV treatment is not recommended in order to avoid liver decompensation due to flares of liver enzymes.
7. In case of chemotherapy or other immunosuppression (e.g. rituximab-treatment) TDF/TAF should be added as prophylaxis in HBsAg-positive persons without HBV active ART (including 3TC) regardless of baseline HBV-DNA levels, see [Solid Organ Transplantation \(SOT\) in HIV-positive Persons](#).
8. Anti-HBc positive persons treated with severe immunosuppressive therapy (chemotherapy for lymphoma/leukaemia or stem-cell or solid-organ transplantation) should receive TDF/TAF therapy to prevent HBV reactivation. For persons with other markers of possible HBV exposure including isolated anti-HBs positivity (without a history of vaccination) careful monitoring for HBV reactivation is required.
9. In anti-HBc positive persons treated with other immunosuppressive therapy (e.g. TNF alpha inhibitor, rituximab) careful monitoring with HBV-DNA and HBsAg is required for HBV re-activation. If this is not possible, addition of TDF/TAF is recommended.
10. In case of non-response to HBV vaccinations, ART should contain TDF or TAF.

Diagnostic Procedures for HCV in Persons with HCV/HIV Co-infection

Diagnosis of HCV
HCV-Ab (turn positive 1-6 months after infection as late seroconversions have been described, may rarely be lost due to immunosuppression)
HCV-RNA levels ⁽ⁱⁱ⁾
Evaluation of concurrent causes of liver disease and/or extra-hepatic HCV disease
Alcohol consumption, cardiac disease, renal impairment, autoimmunity, genetic or metabolic liver diseases (e.g. genetic haemochromatosis, diabetes mellitus or obesity) and drug-induced hepatotoxicity
Status of liver damage
Staging of fibrosis (e.g. FibroScan, liver biopsy, serum fibrosis markers ⁽ⁱⁱⁱ⁾)
Complete blood count, ALT, AST, GGT, ALP, hepatic synthetic function (e.g. coagulation, albumin, cholinesterase)
Ultrasound every 6 months if cirrhosis (gastroscopy upon diagnosis of cirrhosis and every 3-4 years thereafter according to presence of ongoing liver disease if negative for oesophageal varices), see page 57
Before IFN-free HCV treatment
HCV genotype (GT) ⁽ⁱⁱⁱ⁾ , HCV-RNA, renal and liver function tests
Monitoring of IFN-free HCV treatment
In persons with advanced fibrosis (\geq F3) differential blood count, creatinine, liver enzymes, bilirubin, albumin and INR after 2-4 weeks of therapy. In HBsAg negative persons with anti-HBc monitoring of ALT and HBV DNA in case of ALT elevation is recommended.
HCV-RNA during therapy only in order to assess compliance and/or breakthrough in persons experienced to oral DAAs; HCV-RNA at end-of-treatment and at week 12 or 24 after treatment cessation (to assess SVR). In persons receiving all oral DAA therapy no association between viral load at any given time-point during therapy and SVR has yet been found. If HCV-RNA determination is not available SVR can be identified by a negative HCVAg 24 weeks after treatment end.
CD4 count and HIV-VL every 12 weeks

- i There is no standard conversion formula for converting the amount of HCV-RNA reported in copies/mL to the amount reported in IU/mL. The conversion factor ranges from about one to five HCV-RNA copies per IU/mL.
- ii Serum fibrosis markers include APRI, FIB-4, Hyaluronic acid, Fibrometer, Fibrotest, Forns, Hepascore and other indices; recently more complex tests such as Fibrometer, Fibrotest and Hepascore have shown to more accurately predict liver fibrosis than simple biochemical tests such as APRI, FIB-4 or Forns. F4 diagnosis made by transient elastography measurement should be validated by a biomarker score, signs of cirrhosis in liver in sonography or at least repetition of transient elastography after 6 months. F3 diagnosis made by transient elastography measurement should be confirmed by a second measurement after 6 months. Cut-offs for F4 (cirrhosis): 13.0 kPa, for F3: 10.0 kPa (<http://www.easl.eu/research/our-contributions/clinical-practice-guidelines/detail/easl-recommendations-on-treatment-of-hepatitis-c-2018>) and page 58. For HCC, see [General Recommendation for Persons with Viral Hepatitis/HIV Co-infection](#), [Cancer: Screening Methods](#) and [Liver Cirrhosis: Management](#).
- iii If the person is candidate for pangenotypic drugs, HCV GT determination is not mandatory before starting anti-HCV treatment. Re-test for GT and sub-type should be performed in persons with tests carried out before second-generation tests were available (second-generation line-probe assay or real-time PCR assay) or in persons at risk of 'super-infection' for whom the GT/sub-type should be performed on most recent available specimen.

See online video lectures [HCV/HIV Co-infection-Part 1](#), [HCV/HIV Co-infection-Part 2](#) and [HCV/HIV Co-infection-Part 3](#) from the EACS online course Clinical Management of HIV.

Treatment of HCV in Persons with HCV/HIV Co-infection

Treatment indication

1. Every person with HCV/HIV co-infection must be considered for DAA-based (IFN- and preferably also RBV-free) anti-HCV treatment regardless of liver fibrosis stage.
2. Due to similar HCV cure rates and tolerability in HCV/HIV co-infected persons as in HCV mono-infected persons under DAA therapy, treatment indication and regimens are to be the same as in HCV mono-infection.
3. Re-test for GT and sub-type should be performed in persons with tests carried out before second-generation tests were available (second-generation line-probe assay or real-time PCR assay) or in persons at risk of 'super-infection' for whom the GT/sub-type should be performed on the most recent available specimen.

Treatment selection

4. IFN- and preferably also RBV-free DAA combinations are now standard of care for chronic HCV see [HCV Treatment Options in HCV/HIV Co-infected Persons](#). IFN-containing HCV regimens are no longer recommended. For diagnostics and management of IFN-containing HCV regimens please refer to previous versions of these Guidelines, available online at http://www.eacsociety.org/files/guidelines_8.2-english.pdf.
5. Selection of DAA combinations is based upon HCV GT, stage of liver fibrosis, pre-treatment history and resistance-associated substitutions (RAS) if tested.
6. Use of older, first generation HCV PIs (boceprevir and telaprevir; only indicated in GT1) are no longer recommended because of increased toxicities. The second generation PI simeprevir can cause hyperbilirubinaemia and skin reactions/photosensitivity.
7. Due to drug-drug interactions in particular HIV and HCV PIs careful checking for interactions is urgently recommended prior to starting HCV therapy, see [Drug-drug Interactions between DAAs and ARVs](#) or <http://www.hep-druginteractions.org>.
8. The triple combination of SOF/VEL/VOX is the treatment of choice for re-treatment of persons who failed after a PI- and/or NS5A inhibitor-containing regimen. If this combination is not available, re-treatment strategies should include at least 2 active drug classes according to resistance testing results with a preferential use of one drug with high genetic barrier to resistance and with extended treatment durations and potentially addition of RBV.

Treatment goal

9. The primary aim of HCV treatment is SVR₁₂ defined as undetectable HCV-RNA 12 weeks after the end of therapy (evaluated using sensitive molecular tests) or HCV core antigen levels where HCV- RNA assays are not available or not affordable.

Treatment of acute HCV

10. IFN-containing HCV regimens are no longer recommended. For diagnostics and management of IFN-containing HCV regimens please see online EACS Guidelines v8.2 at http://www.eacsociety.org/files/guidelines_8.2-english.pdf.
11. After diagnosis of acute HCV, HCV-RNA should be measured 4 weeks later. Treatment can be discussed in persons without a decrease of 2*log of HCV-RNA at 4 weeks compared with initial HCV-RNA and in persons with persistent serum HCV-RNA 12 weeks after diagnosis of acute HCV, see [Algorithm for Management of Acute HCV in Persons with HCV/HIV Co-infection](#). Immediate treatment of persons with high risk of transmission should be considered at diagnosis. IFN-free treatment with DAAs is recommended as in non-cirrhotic chronic HCV/HIV co-infection, see pages 85-87. Shorter treatment duration is possible in persons with low baseline HCV-RNA (< 6*log IU/mL) [1]. Enrolment of persons with acute HCV co-infection in ongoing trials using IFN-free DAA combination therapy is strongly encouraged.

HCV Treatment Options in HCV/HIV Co-infected Persons

IFN-free HCV treatment options (preferred regimens in bold, alternative regimens in light)				
HCV GT	Treatment regimen	Treatment duration & RBV usage		
		Non-cirrhotic	Compensated cirrhotic	Decompensated cirrhotics CTP class B/C
1 & 4	EBR/GZR	12 weeks⁽ⁱ⁾		Not recommended
	GLE/PIB	8 weeks	12 weeks	Not recommended
	SOF/LDV +/- RBV	8 weeks without RBV⁽ⁱⁱ⁾	12 weeks with RBV⁽ⁱⁱⁱ⁾	
	SOF/VEL	12 weeks		12 weeks with RBV
	OBV/PTV/r + DSV	8 ^(iv) -12 weeks in GT 1b	12 weeks in GT 1b	Not recommended
	OBV/PTV/r + DSV + RBV	12 weeks in GT 1a	24 weeks in GT 1a	Not recommended
	OBV/PTV/r + RBV	12 weeks in GT 4		Not recommended
	SOF + DCV +/- RBV	12 weeks +/- RBV ^(v)	12 weeks with RBV ⁽ⁱⁱⁱ⁾	
	SOF + SMP +/- RBV	GT 4 only: 12 weeks with RBV or 24 weeks without RBV ^(vi)		Not recommended
	SOF/VEL/VOX	8 weeks ^(vii)	12 weeks	Not recommended
2	GLE/PIB	8 weeks	12 weeks	Not recommended
	SOF/VEL	12 weeks		12 weeks with RBV
	SOF + DCV	12 weeks		12 weeks with RBV
	SOF/VEL/VOX	8 weeks ^(vii)	12 weeks	Not recommended
3	GLE/PIB	8 weeks^(viii)	12 weeks^(viii)	Not recommended
	SOF/VEL +/- RBV	12 weeks +/- RBV^(ix) or 24 weeks without RBV	12 weeks with RBV or 24 weeks without RBV	
	SOF + DCV +/- RBV	12 weeks +/- RBV ^(ix) or 24 weeks without RBV	24 weeks with RBV	
	SOF/VEL/VOX	8 weeks ^(vii)	12 weeks	Not recommended
5 & 6	GLE/PIB	8 weeks	12 weeks	Not recommended
	SOF/LDV +/- RBV	12 weeks +/- RBV^(vi)	12 weeks with RBV⁽ⁱⁱⁱ⁾	
	SOF/VEL	12 weeks		12 weeks with RBV
	SOF + DCV +/- RBV	12 weeks +/- RBV or 24 weeks without RBV ^(vi)	12 weeks with RBV ⁽ⁱⁱⁱ⁾	
	SOF/VEL/VOX	8 weeks ^(vii)	12 weeks	Not recommended

DCV = daclatasvir
DSV = dasabuvir
EBR = elbasvir
GLE = glecaprevir
GZR = grazoprevir
LDV = ledipasvir
OBV = ombitasvir
PIB = pibrentasvir
PTV/r = paritaprevir/RTV
RBV = ribavirin
SMP = simeprevir
SOF = sofosbuvir
VEL = velpatasvir
VOX = voxilaprevir
RAS = resistance associated substitutions

- i** Extension of treatment to 16 weeks and addition of RBV in persons with GT1a with baseline HCV-RNA > 800.000 IU/mL and/or NS5A RASs causing at least 5-fold reduction in activity of EBR to minimise the risk of treatment failure and in HCV GT4 experienced persons with HCV-RNA > 800.000 IU/mL. 8 weeks in GT 1b treatment-naïve with F0-F2.
- ii** 8 weeks treatment without RBV only in treatment-naïve persons with F < 3 and baseline HCV-RNA < 6 million IU/mL.
- iii** In persons intolerant to RBV, treatment may be prolonged to 24 weeks. RBV can be omitted in treatment-naïve or -experienced persons with compensated cirrhosis without baseline NS5A RAS.
- iv** 8 weeks treatment without RBV only in persons without cirrhosis.
- v** Addition of RBV in GT1a treatment experienced persons, but not in persons without NS5A RASs, if RASs testing is available.
- vi** In treatment experienced (exposure to IFN/RBV/SOF) persons RBV treatment for 12 weeks or prolong treatment to 24 weeks without RBV.
- vii** Extension of treatment to 12 weeks in DAA treatment experienced persons.
- viii** Treatment duration in HCV GT3 who failed previous treatment with IFN and RBV +/- SOF or SOF and RBV should be 16 weeks.
- ix** Addition of RBV only in treatment experienced persons with baseline NS5A RASs, if RAS testing available; if these persons are intolerant to RBV, treatment may be prolonged to 24 weeks without RBV.

Drug-drug Interactions between DAAs and ARVs

HCV drugs	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	BIC	DTG	EVG/c	RAL	ABC	FTC	3TC	TAF	TDF
DAAs	daclatasvir	↑ ⁱ	↑110% ⁱ	↑	↑41%	↑15%	↓32% ⁱⁱ	↓	↓	↔	↔	↔	E33%	↑	↔	↔	↔	↔	↑10% E10%
	elbasvir/ grazoprevir	↑	↑	↑	↑	↑	↓54/83%	↓	↓	↔	↔	↔	↔	↑	E43%	↔	↔	↔	↓7/14% E34%
	glecaprevir/ pibrentasvir	↑	↑553/64%	↑	↑397%/-	↑338/146%	↓	↓	↓	E84%	E	E	↔	↑205/57% E47%	E47%	↔	↔	↔	E29%
	parita- previr/r/ ombitasvir/ dasabuvir	↑	↑94% ⁱⁱⁱ	↑	D ^{iv}	↑	vi	↓E	↓E	E ^{vii}	E	E	↔	↑	E134%	↔	↔	↔	E
	parita- previr/r/ombi- tasvir	↑	↑ ⁱⁱⁱ	↑	↑ ^v	↑	vi	↓E	↓E	E ^{vii}	E	E	↔	↑	E20%	↔	↔	↔	E
	simeprevir	↑	↑	↑	↑	↑	↓71%	↓	↓	↑6% E12%	↔	↔	↔	↑	↓11% E8%	↔	↔	↔	↓14% E18%
	sofosbuvir/ ledipasvir	↑ ^{viii}	↑8/113% ^{viii}	↑ ^{viii}	↑34/ 39% ^{viii}	↔ ^{viii}	↓-34%	↔	↔	↔ ^{viii}	E	↔	↔	↑36/ 78% ^{viii}	D≈20%	↔	↔	↔	E ^{viii}
	sofosbuvir/ velpatasvir	↔ ^{viii}	↑-142% ^{viii}	↔ ^{viii}	↓28%/- ^{viii}	↓29%/- ^{viii}	↓-53%	↓	↓	↔	E	↔	↔	↑ ^{viii}	↔	↔	↔	↔	E ^{viii}
	sofosbuvir/ velpatasvir/ voxilaprevir	↑	↑40/93/331%	↑ ^{viii}	↑-/ 143% ^{viii}	↑	↓	↓	↓	↔	E	↔	↔	↑-/-171% viii	↔	↔	↔	↔	E ^{viii}
	sofosbuvir	↔	↔	↑	↑34%	↔	↔	↔	↔	↔	↔	↔	↔	↔	↓5%D27%	↔	↔	↔	↔

Legend

- ↑ potential elevated exposure of DAA
- ↓ potential decreased exposure of DAA
- ↔ no significant effect
- D potential decreased exposure of ARV drug
- E potential elevated exposure of ARV drug

Numbers refer to decreased/increased AUC of DAAs and ARVs as observed in drug interactions studies. First/second numbers refer to AUC changes for EBR/GZR or GLE/PIB or SOF/LDV or SOF/VEL
First/second/third numbers refer to AUC changes for SOF/VEL/VOX

ATV/c ATV co-formulated with COBI (300/150 mg qd);
DRV/c DRV co-formulated with COBI (800/150 mg qd)

- ⁱ DCV should be reduced to 30 mg qd with ATV/r or EVG/c. No dose reduction with unboosted ATV
- ⁱⁱ DCV should be increased to 90 mg qd
- ⁱⁱⁱ use only with unboosted ATV (ATV increased PTV exposure due to CYP3A4 and OATP1B1/3 inhibition, not recommended without DSV)
- ^{iv} co-administration decreased DRV trough concentration by approximately 50%. Although co-administration of DRV with OBV/PTV/r + DSV is not recommended in the US Prescribing Information, the European SPC advises that DRV (dosed at 800 mg qd and administered at the same time as OBV/PTV/r + DSV) can be used in the absence of extensive HIV PI resistance and should be taken without additional RTV
- ^v not recommended due to increase in PTV exposure when co-administered with DRV 800 mg given with OBV, PTV, RTV (Viekirax). Of note: exposures of PTV greater than this have been evaluated in phase 2 studies and were not expected to have a clinically meaningful impact on safety
- ^{vi} severe tolerability issues
- ^{vii} not recommended unless benefit outweighs the risk due to potential for QT interval prolongation with higher concentrations of RPV, co-administration should be only considered in persons without known QT prolongation and without other QT prolongation co-medicines
- ^{viii} monitoring of kidney function recommended due to increase of tenofovir concentration if the regimen contains TDF

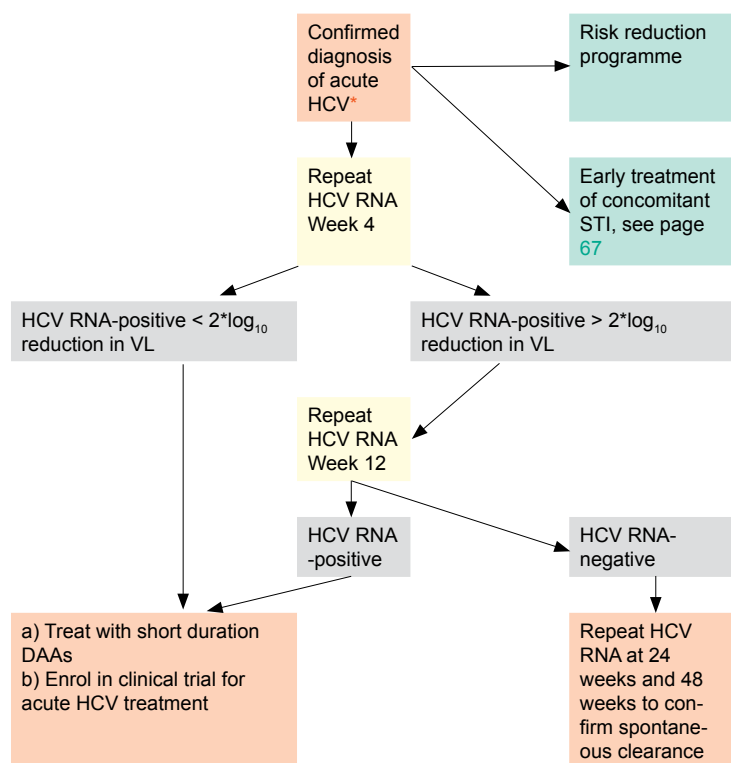
Note: no clinically significant interactions expected between ZDV and DAAs

Colour legend

- no clinically significant interaction expected
- these drugs should not be co-administered
- potential interaction which may require a dosage adjustment or close monitoring
- potential interaction likely to be of weak intensity. Additional action/monitoring or dosage adjustment is unlikely to be required

Note: the symbol (green, amber, red) used to rank the clinical significance of the drug interaction is based on <http://www.hep-druginteractions.org>.

Algorithm for Management of Acute HCV in Persons with HCV/HIV Co-infection



* Where available initiate DAA-based treatment immediately in persons with high risk of onward transmission.

Part V Opportunistic Infections

Prevention and Treatment of Opportunistic Infections (OIs) in HIV-positive Persons

This section provides an overview of the most important aspects in management of the most frequent OIs occurring in HIV-positive persons in Europe. For more detailed discussion, we refer to national guidelines [1-7].

Recommendations for timing on ART initiation in HIV-positive persons with OIs, see [Recommendations for Initiation of ART In HIV-positive Persons with Chronic Infection without prior ART Exposure](#).

See online video lectures [HIV and Pulmonary Infections-Part 1](#), [HIV and Pulmonary Infections-Part 2](#) and [HIV and Pulmonary Infections-Part 3](#) and [CNS and HIV-related opportunistic infections-Part 1](#) and [CNS and HIV-related opportunistic infections-Part 2](#) from the EACS online course Clinical Management of HIV.

Primary Prophylaxis of OIs according to stage of immunodeficiency

CD4 count threshold/indication			
CD4 count < 200 cells/μL, CD4 percentage < 14%, recurrent oral thrush, or relevant concomitant immunosuppression*			
Prophylaxis against <i>Pneumocystis jirovecii</i> Pneumonia (PcP) & <i>Toxoplasma gondii</i>			
Stop: if CD4 count > 200 cells/μL over 3 months or CD4 count 100-200 cells/μL and HIV-VL undetectable over 3 months			
* e.g. use of corticosteroids > 20 mg prednisone equivalent per day for > 2 weeks, cancer chemotherapy, biological agents such as rituximab and others. Decisions on installation and discontinuation in these situations have to be taken individually.			
	Drug	Dose	Comments
Positive or negative serology for toxoplasmosis	TMP-SMX	1 double-strength tablet (ds) (800/160 mg) 3 x/week po or 1 single-strength tablet (ss) (400/80 mg) 1 x/day po or 1 ds tablet 1 x/day po	
Negative serology for toxoplasmosis	pentamidine	300 mg in 6 mL sterile water 1 x inhalation/month	Does not prevent the rare extrapulmonary manifestations of <i>P. jirovecii</i>
Negative serology for toxoplasmosis	dapsone	1 x 100 mg/day po	Check for G6PD-deficiency
Negative serology for toxoplasmosis	atovaquone suspension	1 x 1500 mg/day po (with food)	
Positive serology for toxoplasmosis	dapsone + pyrimethamine + folinic acid	200 mg 1 x/week po 75 mg 1 x/week po 25-30 mg 1 x/week po	Check for G6PD-deficiency
Positive serology for toxoplasmosis	atovaquone suspension +/- pyrimethamine + folinic acid	1 x 1500 mg/day po (with food) 75 mg 1 x/week po 25-30 mg 1 x/week po	
CD4 count < 50 cells/μL			
Prophylaxis against Non-Tuberculous Mycobacteria (NTM) (<i>M. avium complex</i>, <i>M. genavense</i>, <i>M. kansasii</i>)			
Only consider prophylaxis if no clinical suspicion of disseminated NTM. Prophylaxis can be withheld if cART started within four weeks.			
Stop: if CD4 count > 100 cells/μL over 3 months and person on effective ART (and HIV-VL undetectable in the opinion of some experts)			
Regimens listed are alternatives	azithromycin	1 x 1200-1250 mg/week po	Check for interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs
	or clarithromycin	2 x 500 mg/day po	
	or rifabutin	1 x 300 mg/day po	Check for interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs

Primary Prophylaxis, Treatment and Secondary Prophylaxis/Maintenance Treatment of Individual OIs

Pneumocystis jirovecii Pneumonia (PcP)

Primary prophylaxis			
Start: if CD4 count < 200 cells/μL, CD4 percentage < 14%, oral thrush or relevant concomitant immunosuppression (see above)			
Stop: if CD4 count > 200 cells/μL over 3 months or CD4 count 100-200 cells/μL and HIV-VL undetectable over 3 months			
	Drug	Dose	Comments
Negative or positive serology for toxoplasmosis	TMP-SMX	1 double-strength tablet (ds) (800/160 mg) 3 x/week po or 1 single-strength tablet (ss) (400/80 mg) 1 x/day po or 1 ds tablet /1 x/day po	
Negative serology for toxoplasmosis	pentamidine	300 mg in 6 mL aqua 1 x inhalation/month	Does not prevent the rare extrapulmonary manifestations of P. jirovecii
Negative serology for toxoplasmosis	dapsone	1 x 100 mg/day po	Check for G6PD-deficiency
Negative serology for toxoplasmosis	atovaquone suspension	1 x 1500 mg/day po (with food)	
Positive serology for toxoplasmosis	dapsone	200 mg 1 x/week po	Check for G6PD-deficiency
	+ pyrimethamine	75 mg 1 x/week po	
	+ folinic acid	25-30 mg 1 x/week po	
Positive serology for toxoplasmosis	atovaquone suspension +/- pyrimethamine + folinic acid	1 x 1500 mg/day po (with food) 75 mg 1 x/week po 25-30 mg 1 x/week po	
Treatment			
Treat at least 21 days , then secondary prophylaxis until CD4 count > 200 cells/μL and HIV-VL undetectable over 3 months.			
Diagnosis:			
- Definitive diagnosis: Cough and dyspnoea on exertion AND diagnosis by cytology / histopathology of induced sputum (sensitivity up to 80%), broncho-alveolar lavage (sensitivity > 95%) or bronchoscopic tissue biopsy (sensitivity > 95%)			
- Presumptive diagnosis: CD4 count < 200 cells/ μL AND dyspnoea / desaturation on exertion and cough AND radiology compatible with PcP AND no evidence for bacterial pneumonia AND response to PcP treatment			
	Drug	Dose	Comments
Preferred therapy	TMP-SMX	3 x 5 mg/kg/day TMP iv/po + 3 x 25 mg/kg/day SMX iv/po	
	+ prednisone if PaO ₂ < 10 kPa or < 70 mmHg, or alveolar/arterial O ₂ gradient > 35 mmHg. Start prednisone preferentially 15-30 min before TMP/SMX	2 x 40 mg/day po 5 days 1 x 40 mg/day po 5 days 1 x 20 mg/day po 10 days	Benefit of corticosteroids if started within 72 hours after start of treatment
Alternative therapy for <i>moderate to severe PcP</i>	primaquine	1 x 30 mg (base)/day po	Check for G6PD deficiency
	+ clindamycin	3 x 600-900 mg/day iv/po	
	or pentamidine	1 x 4 mg/kg/day iv (infused over 60 min.)	
	For each regimen: + prednisone , if PaO ₂ < 10 kPa or < 70 mmHg, or alveolar/arterial O ₂ gradient > 35 mmHg. Start prednisone preferentially 15-30 min before TMP/SMX. Some experts recommend adding caspofungin to stand-ard treatment in persons with severe PcP (requiring intensive care unit admission)	2 x 40 mg/day po 5 days 1 x 40 mg/day po 5 days 1 x 20 mg/day po 10 days 1 x 70 mg iv day 1, then 1 x 50 mg/day iv	Benefit of corticosteroids if started within 72 hours after start of treatment
Alternative therapy for <i>mild to moderate PcP</i>	primaquine	1 x 30 mg (base)/day po	Check for G6PD deficiency
	+ clindamycin	3 x 600-900 mg/day po	
	or		
	atovaquone suspension	2 x 750 mg/day po (with food)	
	or		
	dapsone	1 x 100 mg/day po	Check for G6PD deficiency
+ trimethoprim	3 x 5 mg/kg/day po	In case of rash: reduce dose of TMP (50%), antihistamines	

Secondary prophylaxis / Maintenance treatment			
Stop: if CD4 count > 200 cells/μL and HIV-VL undetectable over 3 months			
	Drug	Dose	Comments
Negative or positive serology for toxoplasmosis	TMP-SMX	1 ds tablet (800/160 mg) 3 x/week po or 1 ss tablet (400/80) mg 1 x/ day po or 1 ds tablet 1 x/day po	
Negative serology for toxoplasmosis	pentamidine	300 mg in 6 mL sterile water 1 x inhalation/month	Not to use in the rare case of extrapulmonary manifestations of <i>P. jirovecii</i>
Negative serology for toxoplasmosis	dapsone	1 x 100 mg/day po	Check for G6PD-deficiency
Negative serology for toxoplasmosis	atovaquone suspension	1 x 1500 mg/day po (with food)	
Positive serology for toxoplasmosis	dapsone + pyrimethamine + folinic acid	200 mg 1 x/week po 75 mg 1 x/week po 25-30 mg 1 x/week po	Check for G6PD-deficiency
Positive serology for toxoplasmosis	atovaquone suspension +/- pyrimethamine + folinic acid	1 x 1500 mg/day po (with food) 75 mg 1 x/week po 25-30 mg 1 x/week po	

Toxoplasma gondii

Encephalitis

Primary prophylaxis			
Start: if CD4 count < 200 cells/μL, or CD4 percentage < 14%, oral thrush, or relevant concomitant immunosuppression (see above)			
Stop: if CD4 count > 200 cells/μL over 3 months or CD4 count 100-200 cells/μL and HIV-VL undetectable over 3 months			
	Drug	Dose	Comments
Preferred prophylaxis	TMP-SMX	1 double-strength tablet (ds) (800/160 mg) 3 x/week po or 1 single-strength tablet (ss) (400/80 mg) 1 x/day po or 1 ds tablet 1 x/day po	All regimens are also effective against PcP
Alternative prophylaxis	atovaquone suspension	1 x 1500 mg/day po (with food)	
	dapsone + pyrimethamine + folinic acid	200 mg 1 x/week po 75 mg 1 x/week po 25-30 mg 1 x/week po	Check for G6PD-deficiency
	atovaquone suspension + pyrimethamine + folinic acid	1 x 1500 mg/day po (with food) 75 mg 1 x/week po 25-30 mg 1 x/week po	
Treatment			

Treat 6 weeks, then secondary prophylaxis until CD4 count > 200 cells/μL and HIV-VL undetectable over 6 months

Diagnosis:

- **Definitive diagnosis:** clinical symptoms, typical radiology of the cerebrum AND cytological / histological detection of organism
- **Presumptive diagnosis:** clinical symptoms, typical radiology AND response to empirical treatment. It is the standard in most clinical settings.

	Drug	Dose	Comments
Preferred therapy	pyrimethamine	Day 1: 200 mg po, then • If ≥ 60 kg: 1 x 75 mg/day po • If < 60 kg: 1 x 50 mg/day po	Monitor for myelotoxicity of pyrimethamine, mostly neutropenia
	+ sulfadiazine	• If ≥ 60 kg: 2 x 3000 mg/day po/iv • If < 60 kg: 2 x 2000 mg/day po/iv	Sulfadiazine is associated with crystalluria and may lead to renal failure and urolithiasis. Good hydration is essential. Check renal function and urine sediment for microhematuria and crystalluria
	+ folinic acid	1 x 10-15 mg/day po	
Alternative therapy	pyrimethamine	Day 1: 200 mg/day po, then • If ≥ 60 kg: 1 x 75 mg/day po • If < 60 kg: 1 x 50 mg/day po	Monitor for myelotoxicity of pyrimethamine, mostly neutropenia
	+ clindamycin + folinic acid	4 x 600-900 mg/day po/iv 1 x 10-15 mg/day po	Additional PcP prophylaxis is necessary
	or TMP-SMX	2 x 5 mg TMP/kg/day iv/po 2 x 25 mg SMX/kg/day iv/po	Preferred intravenous regimen if oral route not possible
	or pyrimethamine + atovaquone + folinic acid	Day 1: 200 mg po, then If ≥ 60 kg: 1 x 75 mg/day po If < 60 kg: 1 x 50 mg/day po 2 x 1500 mg/day po (with food) 1 x 10-15 mg/day po	Monitor for myelotoxicity of pyrimethamine, mostly neutropenia
	or sulfadiazine + atovaquone	• If ≥ 60 kg: 2 x 3000 mg/day po/iv • If < 60 kg: 2 x 2000 mg/day po/iv 2 x 1500 mg/day po (with food)	Sulfadiazine is associated with crystalluria and may lead to renal failure and urolithiasis. Good hydration is essential. Check renal function and urine sediment for microhematuria and crystalluria
	or pyrimethamine + azithromycin + folinic acid	Day 1: 200 mg po, then • If ≥ 60 kg: 1 x 75 mg/day po • If < 60 kg: 1 x 50 mg/day po 1 x 900-1200 mg/day po 1 x 10-15 mg/day po	Monitor for myelotoxicity of pyrimethamine, mostly neutropenia

Secondary prophylaxis / Maintenance therapy

Stop: if CD4 count > 200 cells/ μ L and HIV-VL undetectable over 6 months

Regimens listed are alternatives	sulfadiazine + pyrimethamine + folinic acid	2-3 g/day po (in 2-4 doses) 1 x 25-50 mg/day po 1 x 10-15 mg/day po	Additional PCP prophylaxis is necessary
	or clindamycin + pyrimethamine + folinic acid	3 x 600 mg/day po 1 x 25-50 mg/day po 1 x 10-15 mg/day po	
	or atovaquone suspension + pyrimethamine + folinic acid	2 x 750-1500 mg/day po (with food) 1 x 25-50 mg/day po 1 x 10-15 mg/day po	
	or atovaquone suspension	2 x 750-1500 mg/day po (with food)	
	or TMP-SMX	1 ds tablet (800/160 mg) 2 x/day po	

Cryptococcal meningitis

Treatment

14 days induction therapy, then 8 weeks consolidation therapy, then secondary prophylaxis for at least 12 months. Stop, if CD4 count > 100 cells/ μ L and HIV-VL undetectable over 3 months

Diagnosis: positive microscopy, OR detection of antigen, OR culture from CSF

Other organ manifestations: Cryptococcal infection can also cause a pneumonitis which may be difficult to distinguish from Pneumocystis pneumonia. Infection may also involve other organs or may be disseminated.

Primary prophylaxis: One large RCT in Africa (the REALITY trial [9]) showed that an enhanced infection prophylaxis in severely immunosuppressed persons (< 50 CD4 cells/ μ L) including INH 12 weeks, fluconazole 100 mg/day for 12 weeks, azithromycin 500 mg/day for 5 days and albendazole 400 mg single dose may decrease overall opportunistic infections (including cryptococcal meningitis) and mortality. Whether these findings can be extrapolated to European countries with rapid diagnostics of subclinical cryptococcosis and latent TB, low TB and parasite prevalence and rapid start of cART is questionable.

Pre-emptive therapy: Early stages of disseminated cryptococcal infections may be oligosymptomatic. Newer data from mainly resource limited settings support determination of serum cryptococcal antigen in all newly diagnosed HIV-positive persons with CD4 counts < 100 cells/ μ L. If cryptococcal antigen is detected, CSF should be examined to rule out cryptococcal meningitis. If meningitis is ruled out, pre-emptive therapy with fluconazole 800 mg/day po for two weeks is recommended before starting cART to reduce the risk of unmasking IRIS.

	Drug	Dose	Comments
Pre-emptive therapy	fluconazole	1 x 800 mg/day po for 2 weeks followed by 1 x 400 mg/day po for 8 weeks	In case of: - positive cryptococcal serum antigen - asymptomatic individual - cryptococcal meningitis ruled out by CSF examination
Induction therapy	liposomal amphotericin B + flucytosine	3 mg/kg/day iv 4 x 25 mg/kg/day po	14 days - Then perform lumbar puncture (LP): if CSF culture is sterile, switch to oral regimen - Opening pressure should always be measured, when LP is performed - Repeated LPs or CSF shunting are essential to effectively manage increased intracranial pressure which is associated with better survival - Corticosteroids have no effect in reducing increased intracranial pressure, could be detrimental and are contraindicated - Flucytosine dosage must be adapted to renal function - Defer start of cART for at least 4 weeks - Amphotericin B deoxycholate may not be available in all European countries - Flucytosine may not be available in all European countries. Consider replacing it by fluconazole 2 x 400 mg/day during the induction phase - In resource-limited settings, a large RCT suggested that one week of amphotericin B + flucytosine or two weeks of fluconazole 1200 mg/d plus flucytosine may be acceptable induction regimens [10].
	or amphotericin B deoxycholate + flucytosine	0.7 mg/kg/day iv 4 x 25 mg/kg/day po	
Consolidation therapy	fluconazole	1 x 400 mg/day po (loading dose 1 x 800 mg 1 st day)	8 weeks. Repeated LP until opening pressure < 20 cm H ₂ O See Drug-drug Interactions between ARVs and Non-ARVs

Secondary prophylaxis / Maintenance therapy			
At least 12 months Consider to stop: if CD4 count >100 cells/μL and HIV-VL undetectable over 3 months			
	Drug	Dose	Comments
	fluconazole	1 x 200 mg/day po	See Drug-drug Interactions between ARVs and Non-ARVs

Candidiasis

Oropharyngeal Candidiasis			
Diagnosis: typical clinical appearance, see Drug-drug Interactions Between ARVs and Non-ARVs , for all azole therapies			
	Drug	Dose	Comments
Preferred alternatives	fluconazole	1 x 150-200 mg/day po	Once or until improvement (5-7 days)
	itraconazole	1-2 x 100-200 mg/day po (oral solution fasting)	7-14 days. Be aware of interactions with ARVs, see Drug-drug Interactions Between ARVs and Non-ARVs
	nystatin	3-6 lozenges at 400000 units (aprox. 4-6 mL)/day	7-14 days
	or amphotericin B	3-6 lozenges at 10 mg/day or oral suspension 1-2 g/day (in 2-4 doses)	

Oesophagitis			
Definitive diagnosis: macroscopic inspection at endoscopy, OR histology of biopsy, OR cytology of specimen from the mucosal surface Presumptive diagnosis: if 1. Recent onset of dysphagia AND 2. Oropharyngeal candidiasis			
	Drug	Dose	Comments
Preferred alternatives	fluconazole	1 x 400 mg/day or 400 mg loading dose, then 200 mg/day po	3 days 10-14 days
	consider itraconazole or posaconazole or voriconazole or caspofungin	1-2 x 100-200 mg/day po (oral solution fasting) 2 x 400 mg/day po 2 x 200 mg/day po 1 x 70 mg iv/day, then 1 x 50 mg/day iv	10-14 days. Be aware of interactions with ARVs, see Drug-drug Interactions Between ARVs and Non-ARVs In cases of refractory disease, treat according to resistance testing. Adapt posaconazole and voriconazole dose according to MIC's of candida and drug trough levels.

Histoplasmosis (*Histoplasma capsulatum*)

Treatment			
Diagnosis: antigen detection in blood, urine or broncho-alveolar fluid, OR by positive microscopy, OR mycological culture of blood, urine, broncho-alveolar fluid, CSF or tissue biopsy. Note: CSF, which shows typically a lymphatic pleocytosis, is usually microscopic and culture negative. Detection of Histoplasma antigen or antibody is more sensitive. Though, a clinical diagnosis is possible in case of negative Histoplasma antigen or antibody in CSF, if disseminated histoplasmosis is present and CNS infection is not explained by another cause. Seek expert advice for the use of fluconazole, voriconazole or posaconazole, if itraconazole is not tolerated. Be aware of interactions of azoles with ARVs , see Drug-drug Interactions Between ARVs and Non-ARVs . Measurement of plasma concentration of itraconazole and voriconazole is advised to guide optimal treatment.			
	Drug	Dose	Comments
Severe disseminated histoplasmosis	Induction therapy: liposomal amphotericin B	3 mg/kg/day iv	For 2 weeks or until clinical improvement
	Consolidation therapy: itraconazole	3 x 200 mg/day po for 3 days, then 2 x 200 mg/day po	For at least 12 months
Moderate disseminated histoplasmosis	itraconazole	3 x 200 mg/day po for 3 days, then 2 x 200mg/day po	For at least 12 months
Histoplasma meningitis	Induction therapy: liposomal amphotericin B	5 mg/kg/day iv	For 4-6 weeks
	Consolidation therapy: itraconazole	2 x or 3 x 200 mg/day po	For at least 12 months and until resolution of abnormal CSF findings. Measure plasma concentration of itraconazole.

Secondary prophylaxis / Maintenance therapy			
Stop: if CD4 count > 150 cells/μL and HIV-VL undetectable over 6 months, negative fungal blood cultures, Histoplasma antigen < 2 μg/L and > 1 year treatment Consider long-term suppressive therapy in severe cases of meningitis and in cases of relapse despite adequate treatment			
	itraconazole	1 x 200 mg/day po	
	or fluconazole	1 x 400 mg/day po	

Herpes simplex virus (HSV) infections

Treatment			
Diagnosis: antigen testing / PCR / culture of swab / CSF / biopsy. Clinical appearance of skin lesions not reliable			
	Drug	Dose	Comments
Initial genital / mucocutaneous HSV	valaciclovir	2 x 1000 mg/day po	7-10 days or until lesions healed
	or famciclovir	2 x 500 mg/day po	7-10 days or until lesions healed
	or aciclovir	3 x 400-800 mg/day po	7-10 days or until lesions healed
Recurrent genital / mucocutaneous HSV (> 6 episodes/year)	valaciclovir	2 x 500 mg/day po	Chronic suppressive therapy. Alternatively start early treatment as above if recurrences occur
Severe mucocutaneous lesions	aciclovir	3 x 5 mg/kg/day iv	After lesions begin to regress, switch to oral treatment until lesions have healed
Encephalitis	aciclovir	3 x 10 mg/kg/day iv	14-21 days
Aciclovir resistant mucocutaneous HSV infection	foscarnet	2 x 90 mg/kg/day iv	Until clinical response

Varicella zoster virus (VZV) infections

Treatment			
Diagnosis: typical clinical appearance with/without antibody testing, OR antigen testing / PCR / culture of swab / CSF / biopsy			
	Drug	Dose	Comments
Primary Varicella infection (Chickenpox)	valaciclovir	3 x 1000 mg/day po	5-7 days
Herpes Zoster (Shingles): Not disseminated	valaciclovir	3 x 1000 mg/day po	7-10 days
	or famciclovir	3 x 500 mg/day po	7-10 days
Herpes Zoster: Disseminated	aciclovir	3 x 10 mg/kg/day iv	10-14 days
Encephalitis (including vasculitis)	aciclovir	3 x 10-15mg/kg/day	14-21 days

Cytomegalovirus (CMV) infections

Treatment			
Diagnosis of retinitis: clinical appearance of typical retinal lesions AND response to therapy. PCR of aqueous and vitreous humor optional Diagnosis of esophagitis / colitis: endoscopic presence of ulcerations AND typical histopathological picture (cellular / nuclear inclusion bodies) Diagnosis of encephalitis / myelitis: clinical appearance AND positive PCR in CSF Antibody testing and PCR in blood not useful for diagnosis of end-organ disease			
	Drug	Dose	Comments
Retinitis, immediate sight-threatening lesions	ganciclovir	2 x 5 mg/kg/day iv	21 days, then secondary prophylaxis
	or foscarnet	2 x 90 mg/kg/day iv	
Retinitis, small peripheral retinal lesions	valganciclovir	2 x 900 mg/day po (with food)	14-21 days, then secondary prophylaxis
	or foscarnet	2 x 90 mg/kg/day iv	
	or cidofovir + probenecid + NaCl 0.9% hydration	1 x 5 mg/kg/week iv	2 weeks then every 2 weeks. Cidofovir may not be available in all European countries
Oesophagitis/Colitis	ganciclovir	2 x 5 mg/kg/day iv	Treat 3-6 weeks, respectively until symptoms resolved
	or foscarnet	2 x 90 mg/kg/day iv	
	or valganciclovir	2 x 900 mg/day po (with food)	In milder disease if oral treatment tolerated
Encephalitis/Myelitis	ganciclovir and / or	2 x 5 mg/kg/day iv	Treat until symptoms resolved and CMV replication in CSF has cleared (negative PCR in CSF)
	foscarnet	2 x 90 mg/kg/day iv	Treatment is individualised according to clinical symptoms and response to treatment

Secondary prophylaxis / Maintenance therapy: Cytomegalovirus (CMV) Retinitis

Stop: if CD4 count > 200 cells/μL and HIV-VL undetectable over 3 months			
Regimens listed are alternatives	valganciclovir	1 x 900 mg/day po (with food)	
	or ganciclovir	1 x 5 mg/kg/day (x 5 days/week) iv	
	or foscarnet	1 x 90-120 mg/kg/day (x 5 days/week) iv	
	or cidofovir + probenecid + NaCl 0.9% hydration	1 x 5 mg/kg every 2 weeks iv	Cidofovir may not be available in all European countries

Progressive Multifocal Leukoencephalopathy (PML)

Treatment PML

Definitive diagnosis (laboratory): evidence of JCV-DNA in CSF AND presence of compatible clinical-radiological picture

Definitive diagnosis (histology): typical histological findings with in situ evidence of JCV-DNA antigen or JCV-DNA AND presence of compatible clinical-radiological picture

Presumptive diagnosis: compatible clinical-radiological picture if JCV-DNA in CSF negative or not performed. JCV-DNA in plasma may complement PML diagnosis, particularly if CSF not available. May also be a marker of disease progression [11].

Person off-ART	Initiate cART immediately (following general guidelines for treatment, see Initial Combination Regimen for ART-naïve Adult HIV-positive Persons), INSTI may reasonably be preferred, given the importance of rapid immune reconstitution in PML. Attention should be made to development of IRIS (see below)
Person on-ART, HIV-VL failure	Optimise cART (following general guidelines for treatment, see Virological Failure), INSTI may reasonably be preferred, given the importance of rapid immune reconstitution in PML. Attention should be made to development of IRIS (see below)
Person on-ART, treated for weeks-months or on effective cART	Continue current cART
	Note: There is no specific treatment for JCV infection that proved to be effective in PML outside of anecdotal case reports, therefore there is no recommendation to use the following drugs which previously or occasionally were used in PML: Alpha-IFN, cidofovir, corticosteroids (except for treatment of IRIS-PML, see below), cytarabine, iv immunoglobulins, mefloquine, mirtazapine and topotecan

Treatment Immune Reconstitution Syndrome (IRIS) – PML

Diagnosis:

- **Paradoxical IRIS-PML:** paradoxical worsening of PML symptoms in the context of cART-induced immune-reconstitution AND in association with inflammation at MRI (oedema, mass effect and/or contrast enhancement) or in brain biopsy

- **Unmasking IRIS-PML:** onset of PML in the context of cART-induced immune-reconstitution AND in association with inflammation at MRI (oedema, mass effect, and/or contrast enhancement) or at brain biopsy

Treatment:

- Corticosteroids, e.g. high dose iv methylprednisolone (e.g. 1 g/day for 3-5 days) or iv dexamethasone (e.g. 0.3 mg/kg/day for 3-5 days), followed by oral tapering (e.g. starting with 1 mg/kg/day and taper over 1-6 weeks)

Note: Use of corticosteroids is not justified in persons without signs of inflammation. There are no other treatments that proved to be effective in IRIS-PML outside of anecdotal case reports

Bacillary Angiomatosis (*Bartonella henselae*, *Bartonella quintana*)

Treatment

Diagnosis: typical histology

	Drug	Dose	Comments
	doxycycline	2 x 100 mg/day po	Until improvement (until 2 months)
	or clarithromycin	2 x 500 mg/day po	Possible interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs

Infections with Non-Tuberculous Mycobacteria (NTM) (*M. avium* complex, *M. genavense*, *M. kansasii*)

Primary prophylaxis			
Only consider prophylaxis if no clinical suspicion of disseminated NTM. Prophylaxis can be withheld if cART started within four weeks Stop: if CD4 count > 100 cells/ μ L over 3 months and person on effective ART (and HIV-VL undetectable in the opinion of some experts)			
Regimens listed are alternatives	azithromycin	1 x 1200-1250 mg/week po	Check for interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs
	or clarithromycin	2 x 500 mg/day po	
	or rifabutin	1 x 300 mg/day po	Check for interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs
Treatment			
Diagnosis: clinical appearance and cultures of blood, lymph nodes, bone marrow or other usually sterile specimen. For any treatment regimen, check interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs			
<i>Mycobacterium avium</i> -intracellulare complex (MAC)			
Preferred	clarithromycin + ethambutol + rifabutin	2 x 500 mg/day po 1 x 15 mg/kg/day po 1 x 300 mg/day po	12 months, then secondary prophylaxis
	rifabutin can be replaced by: + levofloxacin or + amikacin	1 x 500 mg/day po 1 x 10-15 mg/kg/day iv	Rifabutin especially indicated if resistance to macrolides or ethambutol is suspected, severe immunodeficiency (CD4 count < 50 cells/ μ L), high bacterial load (> 2*log of CFU/mL of blood), no cART 4th drug to consider for disseminated disease 4th drug to consider for disseminated disease
	azithromycin + ethambutol	1 x 500 mg/day po 1 x 15 mg/kg/day po	Consider additional drugs as above
<i>Mycobacterium kansasii</i>			
	rifampicin + isoniazid + ethambutol	1 x 600 mg/day po (or rifabutin 1 x 300 mg/day po) 1 x 300 mg/day po 1 x 15 mg/kg/day po	12 months after negative culture
	or rifampicin + clarithromycin + ethambutol	1 x 600 mg/day po (or rifabutin 1 x 300 mg/day po) 2 x 500 mg po 1 x 15 mg/day po	12 months after negative culture
Secondary prophylaxis / Maintenance therapy for MAC infection			
Stop: if CD4 count > 100 cells/ μ L and HIV-VL undetectable over 6 months and MAC treatment for at least 12 months			
<i>Mycobacterium avium</i> (MAC) infection Regimens listed are alternatives	clarithromycin + ethambutol	2 x 500 mg/day po 1 x 15 mg/kg/day po	
	or azithromycin + ethambutol	1 x 500 mg/day po 1 x 15 mg/kg/day po	

Cryptosporidiosis (*C. parvum*, *C. hominis*)

Treatment			
Diagnosis of AIDS-defining cryptosporidiosis can be made only in cases of severe immunodeficiency (CD4 count < 100 cells/ μ L) AND chronic diarrhoea (over 4 weeks) by immunofluorescence or acid fast stain of stools or tissue.			
Mainstay of therapy is the induction of ART to restore immune competence with CD4 count > 100 cells/ μ L. Additional measures are symptomatic treatment, rehydration and electrolyte management. All antiprotozoal therapies can be used additively to cART in severe cases, but are not sufficient to achieve protozoal eradication without immune restoration.			
	Drug	Dose	Comments
	nitazoxanide	2 x 500-1000 mg/day po	14 days
	or paromomycin	4 x 500 mg/day po	14-21 days

Cystoisosporiasis (*Cystoisospora belli*, formerly *Isospora belli*)

Treatment			
Diagnosis of AIDS-defining cystoisosporiasis can be made only in cases of chronic diarrhoea (over 4 weeks) by UV fluorescence or microscopy of stools, duodenal aspirates or intestinal tissue biopsy.			
Besides antiprotozoal treatment, additional measures are symptomatic treatment, rehydration and electrolyte management.			
	Drug	Dose	Comments
Preferred therapy	TMP-SMX	2 x 2 double-strength tablet (ds) (800/160 mg)/day po or 2 x 1 double-strength tablet (ds) (800/160 mg) /day po	Treat minimally 10 days, increase duration to 3–4 weeks if symptoms worsen or persist Treat minimally 10 days, increase dose to 2 x 2 ds tablet/day, if symptoms worsen or persist
Alternative therapy, if TMP-SMX is not tolerated	pyrimethamin + folinic acid or ciprofloxacin	1 x 50-75 mg/day po 1 x 10-15 mg/day po 2 x 500 mg/day po	10 days Monitor for myelotoxicity, mostly neutropenia, for pyrimethamin 7 days
Secondary prophylaxis / Maintenance therapy			
Stop: if CD4 count > 200 cells/ μ L and HIV-VL undetectable over 6 months and no signs of persistent cystoisosporiasis			
Preferred therapy	TMP-SMX	1 double-strength tablet (ds) (800/160 mg) 3 x /week po or 1 ds tablet/day po or 2 ds tablet 3 x/week po	
Alternative therapy, if TMP-SMX is not tolerated	pyrimethamin + folinic acid	1 x 25 mg/day po 1 x 10-15 mg/day po	Monitor for myelotoxicity, mostly neutropenia, for pyrimethamin

Leishmaniasis

Treatment			
Diagnosis: microscopy or PCR in smears, body fluids or tissue			
	Drug	Dose	Comments
Preferred treatment	liposomal amphotericin B	1 x 2-4 mg/kg/day iv for 10 consecutive days	Then secondary prophylaxis
	or liposomal amphotericin B	1 x 4 mg/kg/day iv on day 1-5, 10, 17, 24, 31 and 38	
Alternative therapy	lipidcomplex amphotericin B	1 x 3 mg/kg/day iv	10 days
	or amphotericin B deoxycholate	1 x 0.5-1 mg/kg/day iv (total dose 1.5-2 g)	amphotericin B deoxycholate may not be available in all European countries
	or pentavalent antimonium salt (Glucantime®)	1 x 20 mg/kg/day iv or im	4 weeks
	or miltefosine	1 x 100 mg/kg/day po	4 weeks
Secondary prophylaxis / Maintenance therapy			
Consider stopping: if CD4 count > 200-350 cells/ μ L and HIV-VL undetectable over 3 months, no relapse for at least 6 months and negative PCR in blood or negative urinary antigen			
Preferred treatment	liposomal amphotericin B	4 mg/kg every 2-4 weeks iv	
	or lipidcomplex amphotericin B	3 mg/kg every 3 weeks iv	
Alternative therapy	pentavalent antimonium salts (Glucantime®)	20 mg/kg every 4 weeks iv/im	
	or miltefosine	1 x 100 mg/day po	
	or pentamidine	300 mg every 3 to 4 weeks iv	

Diagnosis and Treatment of TB in HIV-positive Persons

Treatment of TB in HIV-positive persons

For standard treatment of TB in HIV-positive persons, including appropriate choice of ARVs, see table and [ART in TB/HIV Co-infection](#)
See online video lectures [TB and HIV Co-infection-Part 1](#) and [TB and HIV Co-infection-Part 2](#) from the EACS online course Clinical Management of HIV.

Disease	Drug	Dose	Comments*
Susceptible <i>Mycobacterium tuberculosis</i>			
Initial phase	rifampicin + isoniazid + pyrazinamide + ethambutol	Weight based	Initial phase for 2 months, then Continuation phase (rifampicin+isoniazid) according to TB type (see below) Possibility to omit ethambutol, if <i>M. tuberculosis</i> is known to be fully drug sensitive Preventive steroid therapy may be considered to avoid IRIS.
Alternative	rifabutin + isoniazid + pyrazinamide + ethambutol	Weight based	Initial phase for 2 months, then Continuation phase according to TB type (see below) Possibility to omit ethambutol, if <i>M. tuberculosis</i> is known to be fully drug sensitive
Continuation phase	rifampicin/rifabutin + isoniazid according to TB type		Total duration of therapy: 1. Pulmonary, drug susceptible TB: 6 months 2. Pulmonary TB & positive culture at 8 weeks of TB treatment: 9 months 3. Extrapulmonary TB with CNS involvement or disseminated TB: 9-12 months 4. Extrapulmonary TB with bone/joint involvement: 9 months 5. Extrapulmonary TB in other sites: 6-9 months

* Intermittent regimens (2 or 3 times per week) are contraindicated in HIV-positive persons. Missed doses can lead to treatment failure, relapse or acquired drug resistance [12].

Diagnosis of Multi-Drug Resistant TB (MDR-TB) / Extensively-Drug Resistant TB (XDR-TB)

MDR-TB/XDR-TB should be suspected in case of:

- Previous TB treatment
- Contact with MDR/XDR-TB index case
- Birth, travel or work in an area endemic for MDR-TB
- History of poor adherence
- No clinical improvement on standard therapy and/or sputum smear positive after 2 months of TB therapy or culture positive at 3 months
- Homelessness/hostel living and in some countries recent/current incarceration
- In areas with very high MDR-TB/XDR-TB prevalence

MDR-TB: Resistance to isoniazid and rifampicin

XDR-TB: Resistance to isoniazid and rifampicin and quinolones and at least one of the following injectable drugs: kanamycin, capreomycin or amikacin

Rapid detection

Gene Xpert or similar technology has the advantage of rapid detection of rifampicin resistance. Drug susceptibility testing is important for optimising treatment.

Some countries/regions have neither of the above and have to use an empirical approach.

Treatment of resistant TB [8]

INH-resistant TB

- RIF or RFB + Z + E for 2 months and RIF or RFB + E for 10 months

Some experts recommend to add a FQ in the intensive phase and replace E by the FQ in the maintenance phase.

Each dose of MDR/XDR-TB regimen should be given as DOT throughout the whole treatment.

- In persons with rifampicin-resistant or MDR-TB, a regimen with at least five effective TB medicines during the intensive phase is recommended, including pyrazinamide and four core second-line TB medicines - one chosen from group A, one from group B, and at least two from group C.
- If the minimum of effective TB medicines cannot be composed as above, an agent from group D2 and other agents from D3 may be added to bring the total to five.
- In persons with rifampicin-resistant or MDR-TB, it is recommended that the regimen be further strengthened with high-dose isoniazid and/or ethambutol.
- Preliminary results of a recent RCT (Nix-TB trial) suggest that a 3-drug combination of pretomanid 200 mg/day, bedaquiline 200 mg tiw after a 3-week load, and linezolid 1200 mg/day during 6 months (3 additional months if culture positive at 4th month) may be at least as effective as the 5-drug regimens suggested above. Majority of cases included were pulmonary TB.

Drug choices

Each empiric regimen should be reassessed and modified if needed once drug sensitivity results become available.

Group A: Fluoroquinolones	<ul style="list-style-type: none"> • levofloxacin (LFX) • moxifloxacin (MFX) • gatifloxacin (G)
Group B: Injectable agents	<ul style="list-style-type: none"> • amikacin (Am) • capreomycin (Cm) • kanamycin (Km) • streptomycin (S): use only if susceptibility is proven and the above medications are unavailable
Group C: Other core second-line agents	<ul style="list-style-type: none"> • ethionamide (ETO) or prothionamide (PTO) • cycloserine (CS) or terizidone (TRD) • linezolid (LZD) • clofazimine (CFZ)
Group D1: Add on agents	<ul style="list-style-type: none"> • pyrazinamide (Z) • ethambutol (E) • high-dose isoniazid (high-dose INH)
Group D2:	<ul style="list-style-type: none"> • bedaquiline (BED) • delamanid (DLM)
Group D3:	<ul style="list-style-type: none"> • p-aminosalicylic acid (PAS) • imipenem-cilastatin (IPM/CLN) • meropenem (MPM) • amoxicillin clavulanate (Amx/CLV) • thioacetazone (THZ)

Duration of MDR/XDR treatment

8 months of intensive phase using 5 or more drugs, followed by 12 months of 3 drugs depending on response.

E.g. 8 months of Z, MFX, Km, OFX, PTO and CS, followed by 12 months of MFX, PTO and CS.

In persons with rifampicin-resistant or MDR-TB who have not been previously treated with second-line drugs and in whom resistance to fluoroquinolones and second-line injectable agents has been excluded or is considered highly unlikely, a shorter MDR-TB regimen of 9-12 months may be used instead of a conventional regimen.

Drug interactions with ART and MDR/XDR regimens

Unless RFB is being used, use normal doses but with caution as few data are available on potential drug interactions, see [ART in TB/HIV Co-infection](#)

Latent tuberculosis	
Indication: TST > 5 mm or positive IGRA or close contacts to persons with sputum smear positive tuberculosis Some national guidelines consider the ethnicity, CD4 count and ART usage to define indication for latent tuberculosis treatment.	
Regimen*	Comments
isoniazid 5 mg/kg/day (max 300 mg) po + pyridoxine (Vit B6) 25 mg/day po	6-9 months Consider 9-month duration in high-prevalent TB countries.
rifampicin 600 mg/day po or rifabutin** po (dose according to current cART)	4 months, check interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs
rifampicin 600 mg/day po or rifabutin** po (dose according to current cART) + isoniazid 5 mg/kg/day (max 300 mg) po + pyridoxine (Vit B6) 25 mg/day po	3 months, check interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs
rifampicin 600 mg 2 x/week po + isoniazid 900 mg 2 x/week po + pyridoxine (Vit B6) 300 mg 1 x/week po	3 months, check interactions with ARVs, see Drug-drug Interactions between ARVs and Non-ARVs
rifapentine 900 mg 1 x/week po + isoniazid 900 mg 1 x/week po	3 months, check interactions with ARVs, see Drug-drug interactions between ARVs and non-ARVs Rifapentine is not yet available in Europe.
rifapentine 450 mg (< 45kg) or 600 mg (> 45kg) /day po + isoniazid 300 mg/day po + pyridoxine (Vit B6) 25 mg/day po [13]	4 weeks, check interactions with ARVs, see Drug-drug interactions between ARVs and non-ARVs rifapentine is not yet available in Europe.

* Other preventive regimens may be considered if high risk of latent infection with MDR/XDR-TB.

** Rifabutin is not a WHO recommended regimen.

References

Green colour refers to specific references used in each section
Black colour refers to general references used in each section

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Please see references for Part III

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Video links

EACS Guidelines	Video lectures	Link to video lecture
Primary HIV Infection	When to Start ART Part 1	https://vimeo.com/197164442/93941a8e75
	When to Start ART Part 2	https://vimeo.com/197167665/3f00ac2634
	What ART to Start Part 1	https://vimeo.com/197374541/32232bd037
	What ART to Start Part 2	https://vimeo.com/197378793/215317ddab
Switch Strategies for Virologically Suppressed Persons	How to Change ART	https://vimeo.com/197161843/ae0c46e0be
Virological Failure	Adherence and Prevention of HIV Drug Resistance	https://vimeo.com/197381327/d7e972c0d5
ART in TB/HIV Co-infection	HIV and the Management of IRIS Part 1	https://vimeo.com/197762901/a147257ffc
	HIV and the Management of IRIS Part 2	https://vimeo.com/197765956/9b61e5d15d
Pre-exposure Prophylaxis	PrEP Part 1	https://vimeo.com/196714648/6a196a71a4
	PrEP Part 2	https://vimeo.com/196716750/a12a32989b
Adverse Effects of ARVs and Drug Classes	Adverse Effects and Monitoring	https://vimeo.com/197275138/3df1c99e55
Cancer: Screening Methods	Clinical Management of Cancers and HIV Part 1	https://vimeo.com/197398883/6cbeebb66e
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	Epidemiology of Cancers Part 1	https://vimeo.com/197749519/afea560124
	Epidemiology of Cancers Part 2	https://vimeo.com/197749948/e7e5062f2d
Prevention of CVD	HIV and CVD, CKD, Endocrinology	https://vimeo.com/197488153/396253a733
Kidney Disease: Definition, Diagnosis and Management	HIV and CVD, CKD, Endocrinology	https://vimeo.com/197488153/396253a733
Lipodystrophy: Prevention and Management	HIV and CVD, CKD, Endocrinology	https://vimeo.com/197488153/396253a733
Algorithm for Diagnosis and Management of HIV-Associated Neurocognitive Impairment (NCI) in Persons without Obvious Confounding Conditions	CNS and HIV Part 1	https://vimeo.com/197280954/e995f1c097
	CNS and HIV Part 2	https://vimeo.com/197370416/ee3655aa09
Diagnostic Procedures for HCV in Persons with HCV/HIV Co-infection	Hepatitis C and HIV Co-infection Part 1	https://vimeo.com/197259934/bc5cac91d1
	Hepatitis C and HIV Co-infection Part 2	https://vimeo.com/197261826/0462d2df0e
	Hepatitis C and HIV Co-infection Part 3	https://vimeo.com/197262690/a323b6cd72
Introduction to OIs	Pulmonary Infections Part 1	https://vimeo.com/197388161/dc24235ab6
	Pulmonary Infections Part 2	https://vimeo.com/197389876/7c26fb8551
	Pulmonary Infections Part 3	https://vimeo.com/197392161/f90020ae21
	CNS and HIV-related Opportunistic Infections Part 1	https://vimeo.com/197752868/34462456dd
	CNS and HIV-related Opportunistic Infections Part 2	https://vimeo.com/197758431/6b2939c62a
Diagnosis and Treatment of TB in HIV-positive Persons	Tuberculosis and HIV Co-infection Part 1	https://vimeo.com/196723861/7a067d0254
	Tuberculosis and HIV Co-infection Part 2	https://vimeo.com/197161188/4e881b687c